

# CHALLENGES FOR CHANGE: PROGRESS REPORT

TO THE JOINT LEGISLATIVE GOVERNMENT  
ACCOUNTABILITY COMMITTEE

VERMONT AGENCY OF HUMAN SERVICES (AHS)  
ADDENDUM

MARCH 30, 2010





## Table of Contents

<b><u>Section</u></b>	<b><u>Page</u></b>
Overview	6
Outcomes and Measurements	20
AHS Integrated Family Services	26
Integrated Child Development Services	34
Modernization of Benefits Eligibility Determination	37
Improved Child Support Collection	39
Expansion of Blueprint for Health	44
OVHA Direct Care Coordination	56
OVHA Clinical Utilization Review Board	61
Vermont Department of Mental Health/Vermont Department of Health & Alcohol and Drug Abuse Programs	66
Department of Disabilities, Aging and Independent Living	84
Creative Workforce Solutions	88
IT Enterprise Infrastructure	94
Corrections Rebalance	104

# Challenges for Change

## Overview

**CHALLENGES FOR CHANGE**  
OVERALL HUMAN SERVICES CHALLENGE  
MARCH 30, 2010

**Overall Human Services Challenge**

**A. Progress Report**

The solutions developed by the Agency of Human Services to meet the Challenges for Change are based partly on the rapid expansion of existing successful programs like Blueprint for Health and integrated service delivery initiatives in the Department of Children and Families and partly on rapid innovation by agency management and employees in response to the challenges.

There are several unifying themes in the responses to the four sub-challenges posed by the legislature to the agency:

- Integration of the services offered to a family or individual across the many silos of existing programs
- Substituting more effective lower cost strategies like preventive care for more disruptive and expensive treatments like emergency room care
- Providing a pathway to full or partial independence
- Managing vendors and grantees by outcomes

Brief descriptions of the sub-challenges are on the pages that follow in this report. Much more complete descriptions of the progress made to date on these challenges as well as detailed measures for the outcome mandated by the legislature can be found in an appendix to this document devoted to the AHS Challenges.

In order to enhance its response to all the challenges, AHS is also undertaking two agency wide initiatives outlined here and detailed in the AHS appendix.

**Employment Workgroup Initiative**

Employment research has repeatedly shown that having and keeping a job reduces dependency on services and benefits for Agency of Human Services (AHS) consumers. The Challenges Workgroup has developed a consolidated and coordinated approach to employment services, moving from services dispersed across AHS to a single entity within AHS called Creative Workforce Solutions (CWS). CWS will provide equal access to meaningful work in the competitive job market for all AHS program participants. It will also offer employers a single point of contact for coordinated job development and placement services across AHS programs. This approach will significantly improve ease of access for employers.

**Information Technology (IT) Enterprise Infrastructure**

As a foundation to all these specific proposals and in an effort to promote more client centric intake and care management, AHS proposes to modernize the IT infrastructure. The redesign relies on constructing an enterprise architecture for technology, information and the business of AHS. An enterprise architecture creates a roadmap for the use by the same or similar

technologies across the all of AHS. These will provide guidance for future investments. It is built on the principles and products of a service oriented architecture (SOA) of common technologies and shared services that provide reusable components for various needs. For example, AHS would purchase and install one master-person index or one imaging solution that was configured for Agency wide utilization.

**B. Legislation required**

- legislation that exempts IT investments made in conjunction with the Challenges initiatives, including the purchase and implementation of components of the enterprise architecture including Master Person Index, work flow engine, enterprise bus and rules engine. The exemption could sunset at the end of FY12.

## Corrections Challenge

### A. Progress Report

Central to achieving the objectives of the Corrections' Challenge is creating a unified criminal justice system. This system will utilize strategies to enhance community capacities so that offenders may receive services that reduce needs, such as transitional housing and treatment, at the lowest level of intervention by the Department of Corrections, consistent with public safety. These strategies will ensure that secure incarceration beds are prioritized for those offenders who need a higher level of correctional intervention.

By strengthening community capacities with additional probation office resources (such as staff and electronic monitoring equipment), creating residential substance abuse opportunities, using home confinement/incarceration as a sanction and expanding drug courts, technical violation behavior of lower level offenders can be more effectively addressed.

The incarcerated population and resulting costs can be decreased in line with the Corrections' Challenge goal by:

- Creating alternative sentencing options for the Court, such as home incarceration (24/7 at home) and home confinement (allows for participation in employment, treatment and community service).
- Expanding the time prior to serving the minimum sentence that an offender may be released to reintegration furlough.

A major result of this work will be an overall decrease in the use of incarceration within the Department of Corrections while maintaining public safety through enhanced supervision of offenders (consistent with their level of risk) in the community. Additionally, as this plan is implemented, there should be an increase in the use of alternative sanctions by the Courts, such as reparative board referrals and diversion, and a decrease in the number of people entering the Correctional system. Vermonters who commit crimes will be dealt with at the lowest appropriate level and diverted, wherever feasible, away from incarceration. In the past the Department has utilized electronic monitoring and alternative sanctions as deferring or release mechanisms. We believe that these strategies have lessened, though not erased, the rise in incarceration numbers.

### A. Challenge Outcomes and Proposed Measures

(See the detailed report from AHS in the appendix to this report)

### B. Savings Identified To Date

(See the detailed report from AHS in the appendix to this report)

**D. Summary of Proposed Legislation**

- A. Enact S, 292 as passed by the Senate and expand the bill to include the original Senate Judiciary Committee language regarding DUI 3 and greater.
- B. Amend the reintegration furlough statute, 28 V.S.A. §808(a) (8), to expand its timeframe from 90 days to 180 days for all offenses. DOC's current utilization of reintegration furlough is less than 20%.
- C. Amend 13 V.S.A. §7030(a) to include a sentencing option known as a "supervised release sentence" and prohibit the use of non-consecutive sentences such as a weekend interrupt sentence.
- D. Enact a statute to create a "Supervised Release" status based on the New Hampshire model.
- E. Establish home confinement as an optional condition of release to 13 V.S.A. §7554 and home incarceration as a sentencing option for courts.
- F. Authorize judges to grant "use immunity" to offenders charged with a violation of probation based on new criminal charges.
- G. Enact a statutory limitation on use of arrest warrants and incarceration for failure to pay a fine or surcharge.
- H. Authorize referral of misdemeanants to reparative boards at sentencing and authorize the boards to return such offenders to court for further sentencing for failure to comply with board requirements.
- I. Amend 28 V.S.A. §205(a) (3) (A) to standardize the probation term limit for felonies to a set period of years.
- J. Eliminate mandatory minimums for misdemeanor offenses by amending 23 V.S.A. §674(b) (DLS) and 13 V.S.A. §1028(a) (simple assault on a police officer).
- K. Adjust caseload ratios for lower level offenders.
- L. Combine Community Justice Centers and Diversion Boards to streamline and coordinate their efforts. This proposal was discussed by the stakeholder group as an option to explore for FY12.

## **Client Centric Intake and Care Management**

### **C. Progress Report**

#### **Integrated Family Services**

AHS will design and implement a family and child centered system of early intervention, treatment and support. Funding will be flexible and based on best practices and family needs. The system will strive to intervene early in a preventive fashion, and provide services to the family unit, not just the child. Each child and family in the early intervention, treatment and support system will have measurable goals against which progress will be assessed. We believe this approach will produce better outcomes for children and families, reduce unnecessary administrative work, and save money through earlier intervention and family support.

As part of integrated family services, we propose to improve early childhood services for families while increasing effectiveness by consolidating child development services for families and children through a single community partner contract within each region. This will include consolidating child care referral services for families by changing from 12 local service providers to one statewide entity supported by modern web-based technology and communication systems. Supports for early childhood and after school practitioners and programs will be improved to assure a systemic approach to program consultation, quality improvement, and professional development.

#### **Statewide Expansion - Blueprint Coordinated Health Systems**

We propose to reduce overall healthcare expenditures through the accelerated expansion of the Blueprint model and to expand it to other populations and systems, building off a primary care foundation of medical homes and community health teams. Work is underway with the Office of Vermont Health Access (Medicaid), the Vermont Department of Mental Health, the Vermont Department of Health, as well as non-governmental organizations to develop models of sustainable integrated health services. As an example, planning is underway to establish Mental Health & Substance Use Medical Homes with similar financial reforms that can support high quality outpatient services and preventive care, with reductions in avoidable acute care expenditures. Similar work is underway to expand the Blueprint to pediatric services.

#### **Modernization of Benefits Eligibility Determination**

For the past two years, DCF has been involved in modernizing its processes for determining eligibility for various benefits programs, such as Three Squares and LIHEAP. Staffing will be reduced while consumer access and self service options are increasing. This is being accomplished by utilizing such tools as a Benefits Service Center (call center), Web Access, an Application Processing Center, Specialized Eligibility Determination and Supports for Community Providers. We propose to expand this effort to include eligibility determination for child care financial assistance. This will involve replacing private contracts at 12 community agencies (which have been in place for the past 15 years) and centralizing the work within the ESD eligibility system described above.

**D. Challenge Outcomes and Proposed Measures**

(see the detailed report from AHS in the appendix to this report)

**E. Savings Identified To Date**

(see the detailed report from AHS in the appendix to this report)

**F. Legislation required**

- Statutes detailing the power and authority of the Commissioner of DMH (18 V.S.A. § 7401 must be amended to include the concept of “at risk” into statutes related to serving the target population of children with a severe “Severe Emotional Disturbance” by the DMH. This would give clear authority to provide services earlier.
- Language will be necessary to require commercial insurers to participate, amending previous language (Act 204, 2008) that required commercial insurers to participate in the currently operating Blueprint Integrated Pilots.

## **Support Services Promoting Independence of Elderly and Individuals with Disabilities**

### **A. Progress Report**

DAIL intends to aggressively assist Vermonters to remain independent using home and community based services and as a result reduce nursing home utilization. In some counties in Vermont nearly 60% of all persons needing nursing home level of care are served at home or in alternative community based settings. In other counties, the utilization of home and community based services hovers around 40%. Greater utilization of home and community based services is achievable, with an accompanying reduction in nursing home utilization.

Vermonters who need long term care, and choose home based services, can benefit from more flexibility in how the dollar allocation in their plans of care are utilized. This strategy is intended to allow more participants to remain independent. For example, Choices for Care has a limited set of service options that are paid for on a fee for service basis, unless the consumer chooses the Flexible Choices option, where, with the help of a counselor, the consumer manages his/her budget. Only a small group of consumers have selected this option. DAIL is exploring different payment mechanisms that can provide more flexibility to consumers.

Providers can also benefit from flexibility. For example, moving away from a fee for service system could reduce paperwork requirements and time for both providers and State staff.

DAIL is exploring how to utilize the Developmental Services individualized service plans, which the Designated Agencies (DAs) and Specialized Services Agencies (SSAs) develop with consumers, as performance based contracts based on achieving better outcomes for consumers.

DAIL has also proposed legislative changes to Medicaid estate recovery law to increase revenues for the program to ensure persons most in need can continue to receive services.

Another concept involves redesigning the delivery and financing system to have home and community based providers in the long term care system receive bundled rates based on consumers' needs and preferences. The provider agencies, instead of being specialty providers, would accept the responsibility to provide or arrange for all the services a participant needs. In return the provider would be paid a bundled rate based on a plan of care and perhaps a tiered system of rates. We believe this would create opportunities for savings; but it is a large and complicated change that will require more discussion and design time.

**B. Challenge Outcomes and Proposed Measures**

(see the detailed report from AHS in the appendix to this report)

**C. Savings Identified To Date**

(see the detailed report from AHS in the appendix to this report)

**D. Legislation Required**

- Legislation will be needed to amend Medicaid Estate Recovery law. Such legislation is already under consideration in the legislature.

## **Purchasing Results, Not Units of Service**

### **A. Progress Report**

#### **OVHA Direct Care Coordination**

The Office of Vermont Health Access (OVHA) will expand its direct care coordination capacity in two additional areas of the state to improve the health care and outcomes for Medicaid beneficiaries with significant medical needs. FY11 will focus on two additional areas of the state. This expansion will directly reduce costs in the Medicaid program and if successful will be expanded statewide in FY12.

#### **OVHA Clinical Utilization Review Board**

No later than May 15, 2010, OVHA proposes to establish a Clinical Utilization Review Board, to ensure that medical treatments and services paid for with state health care dollars are safe and clinically effective. This board will work collaboratively with the DMH utilization board and jointly they will address both medical and mental health practices in the Medicaid program. It will also ensure that public funds are used in the most cost effective manner that promotes positive health outcomes. Ultimately, the goal is to provide coverage for evidence-based care that meets the specific needs of our beneficiaries in the most cost-effective manner.

### **B. Challenge Outcomes and Proposed Measures**

(see the detailed report from AHS in the appendix to this report)

### **C. Savings Identified To Date**

(see the detailed report from AHS in the appendix to this report)

### **D. Legislation Required**

- Section 6 of 33 VSA §1903a must be amended to remove language requiring that a private entity administer the program.
- OVHA needs the statutory authority to:
  - Have the final authority to evaluate and implement recommendations of the CURB
  - Develop rules if necessary for the specific recommendations, as prescribed by state and federal guidelines

## **Focus Designated Agencies on Client Outcomes**

### **A. Progress Report**

#### **The Department of Mental Health**

The Agency proposes to improve the mental health of citizens by increasing access, decreasing redundant services and documentation, and actively working with the Blueprint for Health and other areas of health care reform involving OHVA. The Department of Mental Health proposes substantial changes in the adult mental health services area, and smaller changes in other areas of care through partnerships with the designated agencies as well as the Office of Drug and Alcohol Programs and the Department of Disabilities, Aging and Independent Living.

Adult services are now composed of acute care services in Adult Outpatient Programs (AOP) and ElderCare Program (ECP), as well as in Community Rehabilitation and Treatment (CRT), the long term program for adults with serious mental health conditions. The changes proposed will begin to address several challenges. First, the need to provide more flexible services for those longer term consumers who wish to transition towards more independence but who are fearful that they will not have services if they need them in the future. Second, by creating a continuum of service for adults more consumers would be able to benefit from packages that are supportive of their individual choices and needs at the time.

Family and child program redesigns are encompassed in a larger effort to address services across all areas of AHS via Integrated Family Services (IFS) and addressed in a separate proposal. DMH is a full partner in that proposal.

DMH has a number of additional system efficiencies including changes in technology, a centralized crisis line for after hours' coverage, and streamlining of administrative oversight and paperwork to produce additional savings.

#### **Department of Disabilities, Aging and Independent Living**

DAIL is exploring how to utilize the individualized service plans the DA's have with consumers with developmental disabilities as performance based contracts based on better outcomes for consumers.

### **B. Challenge Outcomes and Proposed Measures**

(see the detailed report from AHS in the appendix to this report)

### **C. Savings Identified To Date**

(see the detailed report from AHS in the appendix to this report)

#### **D. Legislation Required**

- The Department of Mental Health (DMH) proposed two areas of legislation for the 2010 session which can be preferred methods for improving outcomes and reducing unnecessary expense to state government. Both bills are focused on the Challenges for Change main concept, to alter areas of service that do not achieve outcomes useful to clients, and/or are poor use of resources by which a better investment of funds could improve the lives of those persons. These two areas, involuntary medication and court ordered forensic observation, were proposed for legislative action in the form of two bills:
  - H. 616 An act relating to involuntary mental health treatment, and
  - H. 631 An act related to court ordered forensic evaluation of criminal defendants.
  
- The Department of Disabilities, Aging and Independent Living will need language will to ensure that efficiencies gained in the developmental services are not subject to continuing benefits during any appeal that might be filed. Individuals may appeal a change in their individual budgets, but continuation of benefits without change shall not apply to efficiencies identified and implemented during the pendency of any appeal.

## Corrections Challenge

### A. Progress Report

Central to achieving the objectives of the Corrections' Challenge is creating a unified criminal justice system. This system will utilize strategies to enhance community capacities so that offenders may receive services that reduce needs, such as transitional housing and treatment, at the lowest level of intervention by the Department of Corrections, consistent with public safety. These strategies will ensure that secure incarceration beds are prioritized for those offenders who need a higher level of correctional intervention.

By strengthening community capacities with additional probation office resources (such as staff and electronic monitoring equipment), creating residential substance abuse opportunities, using home confinement/incarceration as a sanction and expanding drug courts, technical violation behavior of lower level offenders can be more effectively addressed.

The incarcerated population and resulting costs can be decreased in line with the Corrections' Challenge goal by:

- Creating alternative sentencing options for the Court, such as home incarceration (24/7 at home) and home confinement (allows for participation in employment, treatment and community service).
- Expanding the time prior to serving the minimum sentence that an offender may be released to reintegration furlough.
- Utilizing other strategies detailed later in this report

A major result of this work will be an overall decrease in the use of incarceration within the Department of Corrections while maintaining public safety through enhanced supervision of offenders (consistent with their level of risk) in the community. Additionally, as this plan is implemented, there should be an increase in the use of alternative sanctions by the Courts, such as reparative board referrals and diversion, and a decrease in the number of people entering the Correctional system. Vermonters who commit crimes will be dealt with at the lowest appropriate level and diverted, wherever feasible, away from incarceration. In the past the Department has utilized electronic monitoring and alternative sanctions as deferring or release mechanisms. We believe that these strategies have lessened, though not erased, the rise in incarceration numbers.

### G. Challenge Outcomes and Proposed Measures

Detailed in the Corrections section which begins on page 103.

### H. Savings Identified To Date

Detailed in the Corrections section which begins on page 103.

**D. Summary of Proposed Legislation**

- M. Enact S, 292 as passed by the Senate and expand the bill to include the original Senate Judiciary Committee language regarding DUI 3 and greater.
- N. Amend the reintegration furlough statute, 28 V.S.A. §808(a) (8), to expand its timeframe from 90 days to 180 days for all offenses. DOC's current utilization of reintegration furlough is less than 20%.
- O. Amend 13 V.S.A. §7030(a) to include a sentencing option known as a "supervised release sentence" and prohibit the use of non-consecutive sentences such as a weekend interrupt sentence.
- P. Enact a statute to create a "Supervised Release" status based on the New Hampshire model.
- Q. Establish home confinement as an optional condition of release to 13 V.S.A. §7554 and home incarceration as a sentencing option for courts.
- R. Authorize judges to grant "use immunity" to offenders charged with a violation of probation based on new criminal charges.
- S. Enact a statutory limitation on use of arrest warrants and incarceration for failure to pay a fine or surcharge.
- T. Authorize referral of misdemeanants to reparative boards at sentencing and authorize the boards to return such offenders to court for further sentencing for failure to comply with board requirements.
- U. Amend 28 V.S.A. §205(a) (3) (A) to standardize the probation term limit for felonies to a set period of years.
- V. Eliminate mandatory minimums for misdemeanor offenses by amending 23 V.S.A. §674(b) (DLS) and 13 V.S.A. §1028(a) (simple assault on a police officer).
- W. Adjust caseload ratios for lower level offenders.
- X. Combine Community Justice Centers and Diversion Boards to streamline and coordinate their efforts. This proposal was discussed by the stakeholder group as an option to explore for FY12.

# Challenges for Change

## Outcomes and Measurements

## AGENCY OF HUMAN SERVICES CHALLENGES FOR CHANGE

<b>Initiative</b>	<b>Challenge</b>	<b>Outcome</b>	<b>Measurement</b>
Integrated Family Services (pg. 26)	<ul style="list-style-type: none"> <li>Client Centric Intake and Care Mgmt.</li> <li>Purchasing results, not units of Service</li> <li>Focus Designated Agencies on Client Outcomes</li> </ul>	<ul style="list-style-type: none"> <li>Pregnant Women and Young Children Thrive</li> </ul>	<p>Developmental Progress measures used in 0-6 early childhood programs</p> <ul style="list-style-type: none"> <li>Increase the percent of children 0-6 years old who achieve 1 or more of their goals as defined annually in their Integrated Services Family Plan</li> </ul> <p>National HEDIS Measure used in Global Commitment to Health</p> <ul style="list-style-type: none"> <li>Increase the percent of women receiving prenatal and post care in the Global Commitment to Health Population</li> <li>Increase the percent of well child visits in the first 15 months of life-in the Global Commitment to Health Population</li> <li>Increase the percent of well child visits in the third - sixth year of life in the Global Commitment to Health Population</li> </ul> <p>School Readiness Survey Data</p> <ul style="list-style-type: none"> <li>Increase the percent of children who are ready for Kindergarten</li> </ul> <p>Increase the rate of developmental screening in early childhood according to national guidelines</p>
“ “	“ “	<ul style="list-style-type: none"> <li>Children live in Stable and Supported Families</li> </ul>	<ul style="list-style-type: none"> <li>Decrease the rate of child abuse and neglect substantiations</li> <li>Decrease the percent of children and youth in out of home placement</li> <li>Increase positive family reports of experience of care (did you get what you need, were you treated with respect, did it help, etc)</li> <li>The percent of families who have one integrated family plan</li> <li>The percent of goals of integrated family plans which are met</li> </ul> <p>Increase the percent of family and youth competencies outside of the clinical range as measured by the Achenbach System of Emotional Behavioral Assessment. (ASEBA) for children, youth and families.</p>
“ “	“ “	<ul style="list-style-type: none"> <li>Youth Choose Healthy Behaviors</li> </ul>	<ul style="list-style-type: none"> <li>Decrease in the percent of youth reporting substance abuse, smoking and unhealthy behaviors as self reported by youth using the Youth Risk Behavior Survey</li> <li>Implement an assets based data collection tool for youth system wide and report on the percent of youth reporting indicators of positive youth development</li> </ul>

<b>Initiative</b>	<b>Challenge</b>	<b>Outcome</b>	<b>Measurement</b>
CDD Integrated Child Dev. Services (pg. 34)	<ul style="list-style-type: none"> <li>Client Centric Intake and Care Mgmt.</li> <li>Purchasing results, not units of Service</li> <li>Focus Designated Agencies on Client Outcomes</li> </ul>	<ul style="list-style-type: none"> <li>Pregnant Women and Young Children Thrive</li> <li>Children live in Stable and Supported Families</li> <li>Youth Choose Healthy Behaviors</li> </ul>	<ul style="list-style-type: none"> <li>The key outcomes and indicators for this effort are the same as the Integrated Family Services Efforts. Please see that proposal for a complete compilation.</li> </ul>
Modernization of Benefits Eligibility Determination (pg. 37)	Client Centric Intake and Care Management	<ul style="list-style-type: none"> <li>Children live in safe, nurturing, stable, supported families</li> </ul>	<ul style="list-style-type: none"> <li>Average length of time to process applications is decreased</li> <li>Accuracy of determinations is increased (Determined by ongoing QC and by triennial Improper Payments Review)</li> <li>Cost per processed application decreases.</li> <li>Customer satisfaction increases</li> </ul> <p>This initiative will make benefits more accessible to Vermonters much more efficiently.</p>
Improved Child Support Collections (pg. 39)	Client Centric Intake and Care Management	<ul style="list-style-type: none"> <li>Children live in safe, maturing, stable, supported families</li> </ul>	<ul style="list-style-type: none"> <li>Percent of child support cases with collections.</li> <li>Increase in child support collections (\$) to families and to offset TANF Expenditures.</li> <li>Increase in cash medical support (\$) that offset Medicaid expenditures.</li> </ul>
Statewide expansion of Blueprint coordinated Health System (pg. 44)	Client Centric Intake and Care Management	Vermonters receive affordable and appropriate health care at the appropriate time, and health care costs are contained over time	<ul style="list-style-type: none"> <li>A sustained increase in practice adherence with National Committee on Quality Assurance Patient Centered Medical Home standards</li> <li>An increase in the proportion of patients that receive recommended health maintenance and preventive assessments</li> <li>An increase in the proportion of patients that receive guideline based care for chronic conditions</li> <li>An increase in the proportion of patients that achieve improved control of their chronic health condition</li> <li>A shift from episodic to preventive patterns of healthcare and resource utilization including a reduction in avoidable hospitalizations and emergency department visits</li> <li>A reduction in the rate of growth of healthcare expenditures</li> </ul>

<b>Initiative</b>	<b>Challenge</b>	<b>Outcome</b>	<b>Measurement</b>
OVHA Community Care Teams (pg. 56)	Client Centric Intake and Care Management	<ul style="list-style-type: none"> <li>Adults lead healthy and productive lives</li> <li>Vermonters receive affordable and appropriate health care at the appropriate time, and health care costs are contained over time</li> </ul>	<ul style="list-style-type: none"> <li>Reduction in unnecessary inpatient admissions</li> <li>Reduction in unnecessary emergency room (ER) use</li> <li>Increased consumer satisfaction, as measured by the annual Consumer Assessment of Health Plan Satisfaction) (CAHPS) survey</li> </ul>
OVHA Clinical Utilization Review Board (pg. 61)	Client Centric Intake and Care Management	<ul style="list-style-type: none"> <li>Adults lead healthy and productive lives</li> <li>Vermonters receive affordable and appropriate health care at the appropriate time, and health care costs are contained over time</li> </ul>	<ul style="list-style-type: none"> <li>Number of services reviewed by the CURB</li> <li>Number of recommendations implemented</li> <li>Reduction in both the over and under utilization of services (e.g., decreased overuse of elective, non-emergent out-of-state outpatient and hospital services)</li> <li>Member satisfaction, as measured by the annual Consumer Assessment of Health Plan Satisfaction) (CAHPS) survey</li> <li>Changes in costs of medical services for specific medical conditions</li> </ul>
Mental Health (pg. 66)	<ul style="list-style-type: none"> <li>Client Centric</li> <li>Focus Designated Agencies on Client Outcomes</li> </ul>	<ul style="list-style-type: none"> <li>Elders, people with disabilities and individuals with mental health conditions live with dignity and independence in settings they prefer</li> <li>Adults lead healthy and productive lives</li> <li>Vermonters receive affordable and appropriate health care at the appropriate time and health care costs are contained over time.</li> </ul>	<ul style="list-style-type: none"> <li>Decrease response time callers for after hours emergency callers</li> <li>Decrease in redundant quality reviews/decrease administrative cost for DA's to support a 1% productivity</li> <li>Improve employment of CRT consumers, minimally 1.5% annually</li> <li>Goal of 50% of DA clients in 8 locations use FQHC 340-B pharmacy</li> <li>Use of data from DA assessments to identify best practices and outcomes in variety of areas.</li> <li>Decrease use of local hospital emergency departments for emergency intervention/decrease medical and surgical and psychiatric inpatient care for person with Co-Occurring Conditions (substance abuse and mental health conditions)</li> </ul>
DAIL (pg. 84)	<ul style="list-style-type: none"> <li>Client Centric Intake and Care Management</li> <li>Empower Families to Support their elderly</li> <li>Focus Designated Agencies on Client Outcomes</li> </ul>	Elders, people with disabilities and individual with mental health conditions live with dignity and independence in settings they prefer.	<ul style="list-style-type: none"> <li>Nursing home bed days are reduced</li> <li>Number of persons on home and community based programs increase.</li> <li>Percentage of respondents who report that they had a say in the decision about where they live</li> <li>Percentage of respondents who report that they are happy with their case manager</li> <li>Percentage of respondents who report that they are happy with their service agency</li> </ul>

<b>Initiative</b>	<b>Challenge</b>	<b>Outcome</b>	<b>Measurement</b>
Creative Workforce (pg. 88)	<ul style="list-style-type: none"> <li>• Client Centric Intake and Care Mgmt.</li> <li>• Purchasing results, not units of Service</li> <li>• Focus Designated Agencies on Client Outcomes</li> </ul>	<ul style="list-style-type: none"> <li>• Youths successfully transition to adulthood</li> <li>• Elders, people with disabilities, and individuals with mental health conditions live with dignity and independence in settings they prefer,</li> <li>• Adults lead healthy and productive lives,</li> <li>• Families and individuals move out of poverty through education and advancement in employment</li> </ul>	<ul style="list-style-type: none"> <li>• More AHS customers will be employed</li> <li>• Wages will increase</li> <li>• Employment retention will increase</li> <li>• Benefits utilization and recidivism will decrease</li> <li>• Cost per outcome will decrease</li> <li>• Customer satisfaction will increase for employers, consumers and stakeholders</li> </ul>
Corrections Rebalance (pg. 104)	Reduce the number of people entering the corrections system, decrease the recidivism rate, improve community safety and reduce the corrections budget.	Families and individuals live in safe and supportive communities.	<ul style="list-style-type: none"> <li>• Decrease the number of offenders returned to prison for technical violations of probation and parole while ensuring public safety.</li> <li>• Decrease number of offenders coming into the corrections system.</li> <li>• Increase number of nonviolent offenders (in this proposal defined as an offense that does not constitute a listed crime) diverted from prison into the community while ensuring public safety and providing effective behavior.</li> <li>• Decrease in Recidivism</li> <li>• Establish a unified crime prevention and justice system</li> <li>• Increase revenues realized by DOC from programs designed to develop skills of offenders</li> <li>• Decrease short term lodgings</li> </ul>



# Challenges for Change

- Integrated Family Services
- Integrated Child Development Services
- Modernization of Benefits Eligibility Determination
- Improved Child Support Collections

# AHS Integrated Family Services Challenges for Change

## Executive Summary

---

AHS will design and implement a family and child centered system of early intervention, treatment and support. Though reduced to adhere to the *Challenges* constraint, funding will be flexible and based on best practices and family needs. The system will strive to intervene early in a preventive fashion, and provide services to the family unit, not just the child. Each child and family in the early intervention, treatment and support system will have measurable goals against which progress will be assessed.

- The early intervention, treatment and support system will:
  - retain content experts in early childhood, mental health, developmental disability, substance use, etc.,
  - operate with standards for best practice and,
  - develop unified AHS guidelines for effective treatment and family support.
- The early intervention, treatment and support system will be readily available to meet the child protection and guardianship responsibilities of the state.
- The early intervention, treatment and support system must be linked to and support those health and human services which are preventative in nature and which address the whole population and offer developmental, health and behavioral health benefits.
- The early intervention, treatment and support system will actively collaborate with DOE on efforts to unify services for families in a comprehensive manner.

## Goal

Integrate human service efforts to create a continuum of services for families to choose from and base service on diagnostic and functional needs of the child, youth and family.

Services will be guided by best practices in clinical service, early intervention and family support. The system will monitor outcomes and integrate AHS funding across programs in order to meet these goals effectively.

## Operational Design

Currently AHS children's services fall in five Departments and multiple divisions of the agency. Division and departments historically developed separate and distinct Medicaid waivers and Medicaid procedures for managing sub-specialty populations within various departments. While the best approaches available at the time, the artifacts of this history are multiple and fragmented funding streams, policies, and guidelines about our work with children and families. With the inception of the Global Commitment waiver, these siloed Medicaid funding structures no longer exist.

The Integrated Family Services Initiatives seeks to bring all agency children, youth and family services together in an integrated and consistent continuum of services for families. **The premise being that giving families early support, education and interventions will produce more favorable outcomes at a lower cost than the current practice of *waiting until circumstances are bad enough to access high end funding streams which often result in out of home or out of state placement.***

Efforts across the agency in the agency over the past several years have moved in the direction that this initiative champions. For example, DCF- Family Service Division has instituted a Differential Response system which seeks to apply resources and intervention earlier to focus on mitigating risk and thus increase child safety and family unity. VDH- Children with Special health Needs and DCF- Child Development Division and OVHA have been fully integrating administrative and operational procedures for service authorization, billing and tracking for the last 10 months.

The Basic elements of this model will also be integrated with the Blueprint Community Health Teams and the expanded OVHA Chronic Care initiative. The integrated family services effort will support and overtime expand on wellness coaching and ensure a connection with the developing health information exchange network and modernized information technology efforts to maximize their applicability to the child and family services efforts. Additionally, proposals by OVHA and DMH to assure that the best clinical practices are utilized in the Medicaid program will be integral to this initiative relative to clinical practices in mental health, behavioral health, medical and medication management for children, youth and families.

Basic elements of the redesign are detailed in the table on the next page.

**Basic Elements Integrated Family Services  
Policy**

<b><i>From Current</i></b>	<b><i>To Redesign</i></b>
Family centered, child focused	Family systems, strength based & shared decision making with families
Eligible only when <i>bad enough</i>	Early intervention, treatment and support
Diagnosis driven	Diagnostic and functionally driven

**Program**

<b><i>From Current</i></b>	<b><i>To Redesign</i></b>
Separate screenings, intakes and assessments	Common & consistent family screening, intake and multi-disciplinary assessment process
Separate guidelines and criteria	Unified and common AHS guidelines and criteria
Separate programs, separate plans	Integrated services and single plan,
Separate documentation	One common documentation set
Multiple case management/service coordination definitions and providers	One definition and single lead coordinator
Child diagnosis	Family & child functioning
Medical home separate from social/behavioral	Integrated medical home & teaming

**Fiscal, Contract, IT**

<b><i>From Current</i></b>	<b><i>To Redesign</i></b>
Units of service	Bundled rate and outcome measures
Multiple contracts and grants– similar services	Unified and simplified administrative and program oversight activity
Individually negotiated rates/budgets for each provider by each AHS division	Statewide rate/outcomes drive budget
Fragmented or outdated IT	HIE/HIT advances & modern IT structures

**Structural – Central Office**

<b><i>From Current</i></b>	<b><i>To Redesign</i></b>
Individual departments/division	Integrated family services team and global budget for early intervention, treatment and support

**Structural –Regions**

<b><i>From Current</i></b>	<b><i>To Redesign</i></b>
Multiple individual providers with separate systems and standards, intakes, budgets based on separate expectations from each AHS division	Unified local network/continuum for direct services Multi-disciplinary team approach available with consistent guidelines in each region: <ul style="list-style-type: none"> <li>- triage, intake, referral, plan</li> <li>- expert consultation/assessment team</li> </ul>

## Outcome/Indicators

---

### System of Measurement (Annually)

Note: Overtime and with full modernization of the AHS Information technology Infrastructure (see separate detail write-up), more precise longitudinal and other intervention specific measures will be available for implementation in outcome tracking. This capability is currently inhibited by disparate and out dated technology systems and the historical isolation of programs that resulted in separate program and data collection efforts.

Outcome	Indicators
Pregnant Women and Young Children Thrive	<p>Developmental Progress measures used in 0-6 early childhood programs</p> <ul style="list-style-type: none"> <li>• Increase the percent of children 0-6 years old who achieve 1 or more of their goals as defined annually in their Integrated Services Family Plan</li> </ul> <p>Increase the percent of children enrolled in child care programs who regularly attend a quality child development program.</p> <p>National HEDIS<sup>1</sup> Measure used in Global Commitment to Health</p> <ul style="list-style-type: none"> <li>• Increase the percent of women receiving prenatal and post care in the Global Commitment to Health Population</li> <li>• Increase the percent of well child visits in the first 15 months of life-in the Global Commitment to Health Population</li> <li>• Increase the percent of well child visits in the third - sixth year of life in the Global Commitment to Health Population</li> </ul> <p>School Readiness Survey Data</p> <ul style="list-style-type: none"> <li>• Increase the percent of children who are ready for Kindergarten</li> </ul> <p>To be developed</p> <ul style="list-style-type: none"> <li>• Increase the rate of developmental screening in early childhood according to national guidelines</li> </ul>
Children live in Stable and	<ul style="list-style-type: none"> <li>• Decrease the rate of child abuse and neglect</li> </ul>

---

<sup>1</sup> HEDIS (Healthcare Effectiveness Data and Information Set) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 71 measures across 8 domains of care. Because so many health plans collect HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis. Health plans also use HEDIS results themselves to see where they need to focus their improvement efforts. \*HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA)

Outcome	Indicators
Supported Families	substantiations <ul style="list-style-type: none"> <li>• Decrease the percent of children and youth in out of home placement</li> <li>• Increase positive family reports of experience of care (did you get what you need, were you treated with respect, did it help, etc)</li> <li>• The percent of families who have one integrated family plan</li> <li>• The percent of goals of integrated family plans which are met</li> <li>• Increase the percent of family and youth competencies outside of the clinical range as measured by the Achenbach System of Emotional Behavioral Assessment. (ASEBA) for children, youth and families.</li> </ul>
Youth Choose Health Behaviors	<ul style="list-style-type: none"> <li>• Decrease in the percent of youth reporting substance abuse, smoking and unhealthy behaviors as self reported by youth using the Youth Risk Behavior Survey</li> <li>• Implement an assets based data collection tool for youth system wide and report on the percent of youth reporting indicators of positive youth development</li> </ul>

## Savings Goal

5% of total GF in the current AHS system of services targeted at early intervention, treatment and/or family support – estimated at \$2.5 million GF or \$6.5 million Global Commitment.

- 2.5% to come from administrative simplification and global commitment flexibilities
- 2.5% to come from reduction in more costly services by employing a comprehensive model of prevention early intervention and family support across all AHS programs and efforts

## Changes Needed in Statute and Regulation

Statutes detailing the power and authority of the Commissioner of DMH (18 V.S.A. § 7401 should be amended to include the concept of “at risk” into statutes related to serving the target population of children with a severe “Severe Emotional Disturbance” by the DMH. This would give clear authority to provide services earlier.

Analysis needs to be completed in the coming months to determine if the following types of changes are needed

1. Potentially remove eligibility definitions from State Statute and instead place updated process in rule applicable to all AHS programs and not isolated funding streams. This may include changes to Act 264. And changes in the terms that define “Disability” in various DAIL and DMH statutes related to developmental disability.
2. Possible amended or suspend DD Act Regulations for individual up to the age of 22 until updated rules can be put in place for children and family.
3. Potentially remove from statute characteristics of Woodside as a *detention* only facility and recognize a role for the facility in a continuum of care as short term stabilization,

assessment and treatment facility. This would allow both Global Commitment and general funds to support the operations and bring a vital assessment and short term treatment focus to the overall system of care.

4. Possible rule changes in Agency Designation process

## **Timeline for Implementation**

---

July 1, 2010 – Implement strategies to decrease administrative burden within provider system

1. Implement a single set of documentation requirements across all AHS programs
2. Eliminate Child Psychiatric sign off on charts where psychiatric level of care is not warranted
3. Implement a single audit process across AHS programs
4. Determine if converting the use of Woodside to a secure treatment facility is a viable role in the continuum of care.
5. Determine if paying parents to stay at home with their children who have significant physical disabilities is a viable option under Medicaid law and the terms and conditions of the Global Commitment to Health waiver. If so, develop clear criteria and safeguards to prevent, financial or other abuses to the consumer and Medicaid system.
6. Work with OVHA and the Blueprint team to develop communication and other protocols for integration of care coordination and other efforts

October 1, 2010 – Begin program changes to unify guidelines and practices of similar services and services to similar or the same populations

1. Restructure all Early Childhood Programs for families with children prenatal to six years (see Child Development Services detail in separate analysis))
2. Focus all Departments on practice changes that will:
  - a. Reduce hospitalizations and out-of-home placements; For example
    - Combine funding and create one set of guidelines for out-of-home placements
    - Combine funding for IFBS, in home waivers, and some ADAP money for Enhanced Family Treatment and intervene earlier.
  - b. Apply a blended funding model up front to support respite, behavioral consultation, hi-tech services and personal care as needed before family situations escalate to a higher level of need or crisis. Including paying parents to stay at home with their children who have significant physical disabilities if it is determined a viable state option with clear criteria and safeguards.
3. Work with OVHA and DMH utilization management entities to continue analysis of medication management practices within the Medicaid program for youth and families
4. Work with DOE and all AHS programs to integrate and streamline funding and oversight of school based programming for FY12 implementation. For example DMH sponsored School Based Clinicians and Behavioral Interventionist, ADAP sponsored Student Assistance Program services, EPSDT School Nurses and others

### January 1, 2011

1. Begin using IT enhancements to further decrease administrative burden and eliminate redundant business processes. Including the creation of Information exchange technologies that will allow us to identify who are all the families and youth, what they receive for services, costs and outcomes.
2. Implement guidelines for integrated screening, intake and assessment process
3. Implement unified out of home placement guidelines across AHS programs
4. Implement a care management model integrated with OVHA and Blueprint as appropriate for the top 200 beneficiaries with the highest utilization of AHS child and family services

### July 1, 2011

1. Unified and simplified financial structure
2. IT enhancements
3. Outcome tracking

### September 1, 2011

1. Integrate and streamline funding and oversight of school based programming – School Based Clinicians, Behavioral Interventionist and SAPs

### October 1, 2011

1. Implement any best practices identified for better medication management within the Medicaid program for youth and families

## **Investments Needed**

---

1 FTE AHS Senior Leaders established in Secretary Office to oversee and have ultimate authority to implement and monitor initiative and budget objectives.

### Contractor Time

- Ad hoc Policy/Fiscal Analysis – (Pacific Health Policy group)
- 1 FTE Business Process Consultant – (To define work flow for IT)
- .5 FTE Reporting set up and Data Analysis - (timely access to data to answer policy and stakeholder questions)

Accelerated IT development

Backfill positions reassigned to Challenges work.

## **Information Technology (IT) Needs**

---

EMPI - unduplicated information and ability to track for consumers prenatal to 22 years old.

MMIS – service authorizations, ability to make payments from all fund sources combined (not just Medicaid), utilization and costs reports

Case tracking/management tools - within AHS and between AHS and its grantees and contractors

Health Information Exchange networks within AHS and between AHS and its grantees and contractors

Data warehouse and central source for the measurement and integration of data from disparate AHS and provide sources.

## **Stakeholder Involvement**

---

2008-2009 The Integrated Family Service Concepts grew out a process that began with an intensive focus on children and families prenatal to six years old. Stakeholders in these 0-6 year old discussion included legal aid staff, parents and staff from Vermont Children’s health Improvement Program at UVM

July 2009 Families were invited to join AHS staff to begin discussions of the larger continuum of services from prenatal to 22 years of age. The Vermont Federation of Families for Children’s Mental Health sent a designee to what was then a cross departmental work group of AHS staff.

September 2009 – A large Stakeholder group (Educators, DA reps, primary care and family practice doctors, early childhood and other provider networks) were asked to attend a workshop on integrated services and promotion of health and well being for children. This workshop was provided free of cost to Vermont by the Maternal and Child Health Division of Federal Department of Health and Human Services.

Feb 2010 Vermont Family Network joined the AHS discussion by designating a parent representative to group.

March 19, 2010 – A large Stakeholder group was convened for the purpose of getting feedback and guidance on the overall vision, the process and the basic elements of the redesign as well as to indicate interest and willingness to participate in workgroups targeting basic elements of the system redesign. Over 50 participants from all aspects of child, youth and family system (public and private) attended.

In Process - Identify and convene ad hoc work groups on various aspects of the redesign basic elements including participation of providers and other stakeholders.

In Process – Form a 5-7 person parent advisory panel to review guidelines and other products that emerge from the redesign work – youth voice will be added using the current youth in transition grant connection.

On- Going - Individual departments use their existing advisory bodies as needed for input.

# Integrated Child Development Services Challenges for Change

## Executive Summary

---

This Early Childhood challenge is part of the Integrated Family Services (see separate description) efforts. It presents an opportunity to improve early childhood services for families while increasing effectiveness. It also presents the opportunity for more local flexibility in designing a comprehensive approach to the work, rather than asking a wide range of providers to each perform a more narrow set of activities through separate contracts with the Child Development Division (CDD) of the Department for Children and Families.

CDD currently administers a continuum of essential services for children and families in Vermont which range from primary prevention to early intervention and treatment for children and families with particular needs. The programs defining these services have been created as separate initiatives over 25 years and have been consolidated more recently at CDD. Currently, these services are delivered in Vermont communities by 37 different private organizations as 8 connected but still disparate programs. The result is an evolved patchwork of partners that generates multiple points of contact, mixed messages and redundant or overlapping functions. Individuals are burdened with multiple contacts at CDD and separate non-integrated budgets and reporting requirements for different programs.

This effort proposes to build on work of the Division over the past few years and fully integrates all child development services administered by CDD through three related strategies:

- A. Consolidate child development services for families and children in each AHS region through a single community partner contract within each region. Community partners will deliver and coordinate the following services:
  - a. Children's Integrated Services: These services, which include Nursing and Family Support, Early Intervention, and Early Childhood and Family Mental Health, and specialized child care services are fully integrated with the Integrated Family Services "Challenges effort" described elsewhere in the AHS proposal. This prenatal-6 effort has been working toward this goal for the past several years and will be fully connected to Blueprint and integrated AHS efforts to promote developmental, mental and physical health outcomes.
  - b. Parent Child Centers and Learning Together: These services include outreach and information for families, parenting education, peer support, and playgroups, home visiting, support for pregnant and parenting teens and other primary prevention services.
  - c. Building Bright Futures Direct Services: These are services designed and delivered within each community to promote good parenting and healthy child development.

In communities where multiple providers currently deliver portions of this work, the integrated grant is intended to fuse effort and expertise. CDD staff will oversee the work via an integrated grants management team with integrated budgets and reporting requirements and a single point of contact at CDD for each community partner.

Energy and resources will be focused on innovation, integration and the development of data driven policies and strategies that produce positive outcomes for children and families. Significant savings can be achieved while fairly allocating and managing available resources across regions in accord with demonstrated community needs.

- B. Consolidate child care referral services for families by changing from 12 local service providers to one statewide entity supported by modern web-based technology and communication systems with a defined connection to the Vermont 2-1-1 information and referral line. These information services are accessed primarily via telephone and internet. Centralization will improve consistency and quality in customer service while reducing costs. Local assistance for families who require direct help will be provided through the consolidated program outlined in section A above.

Restructure delivery of supports for early childhood and after school practitioners and programs to assure a systemic approach to program consultation, quality improvement, and professional development. The system to advance improved quantity and quality of child care in Vermont will be supported with a consolidated contract that balances access to available resources and consistent, well designed and widely communicated services throughout the state. Some of this work will be centralized, some may be regional, and much will be delivered locally.

### **Outcome/Indicators**

---

The key outcomes and indicators for this effort are the same as the Integrated Family Services Efforts. Please see that proposal for a complete compilation.

### **Estimated Savings and Return on Investment**

---

Savings – Part of the total 6.5 million Integrated Family Service Efforts

### **Changes Needed in Statute and Regulation**

---

None

### **Timeline for Implementation**

---

Part A: Issue RFP for 12 CDD Community Partners in July 2010 with implementation of integrated grants on October 1, 2010.

Transition of specialized child care services between October 1, 2010 and January 31, 2011, depending on current delivery system in particular regions.

Part B & C: Issue two separate RFPs, one for a single statewide child care referral contract and one for a consolidated delivery system of early childhood and after school practitioner and program supports in October 2010 with implementation of new systems by January 31, 2011.

### **Investments Needed**

---

Part A. Minimal – an integrated data system is being designed and developed with Federal ARRA funds – implementation is anticipated in Spring 2011.

Part B. One time IT investment to create data sharing capacity between CDD Bright Futures Information System (BFIS) child care provider data and (National Association of Child Care Resource and Referral Agencies) NACCRRRA-ware software to be used by statewide services provider. Provider training on NACCRAA-ware estimated to cost \$75,000 - \$90,000.

Part C. IT investment to upgrade BFIS centralized capacities related to practitioner qualifications and training and a centralized professional development calendar.  
Approx. \$80,000

## **Information Technology (IT) Needs**

---

See Above

## **Stakeholder Involvement**

---

What has been stakeholder involvement to date? What is planned?

DCF has introduced these concepts to stakeholder groups in the early childhood and after school community: Community Child Care Support Agencies; the Interagency Coordinating Council; the Parent Child Center Network, the Child Care Advisory Board and the Building Bright Futures Council.

Over the next 6 – 8 weeks, staff will continue to engage in substantive discussions with these and other stakeholder groups in every region of the state to gather input and discuss outcomes and strategies. We will seek to fully engage local and state Building Bright Futures teams. Community input will be used to develop RFPs and fine tune the details of this proposal.

# Modernization of Benefits Eligibility Determination Challenges for Change

## Executive Summary

---

For the past two years, DCF has been involved in modernizing its processes for determining eligibility for various benefits programs. The effort currently involves:

- 3SquaresVT
- Health Care Programs
- Home Heating Assistance
- Reach Up
- General Assistance

The primary elements of a modernized system are as the following capabilities across these vertical programs:

- Benefits Service Center (call center)
- Web Access
- Application Processing Center
- Specialized Eligibility Determination
- Supports for Community Providers

The system is designed to be fully functional by June 1, 2010. It is designed to give quicker and more accessible service to individuals while reducing the human resources needed to process benefits eligibility. DCF is slated to be able to save 30 positions on June 1, 2010 as a result of the process improvements.

The “Challenges” effort proposes to expand this effort to include eligibility determination for child care financial assistance. This will involve replacing private contracts at 12 community agencies (which have been in place for the past 15 years) and centralizing the work within the ESD eligibility system described above.

This effort is a prototype for many other services which can be folded into similar technologies.

## Outcome/Indicators

---

The big outcome of this effort will be to achieve the vision described in Challenges as *Client-Centered Intake*:

*Individuals and families will direct their own lives and will be supported in pursuing their own choices, goals, aspirations, and preferences.*

*Individuals and families will have access to apply for health and human services programs for which they are eligible through any department or office of the agency.*

Key to achieving that outcome will be the speed, accuracy, and efficiency of financial eligibility determination, and customer satisfaction with the process.

Key indicators will be:

- Average length of time to process applications
- Accuracy of determinations (Determined by ongoing QC and by triennial Improper Payments Review)
- Cost per processed application
- Customer satisfaction

This initiative will make benefits more accessible to Vermonters much more efficiently.

## **Estimated Savings and Return on Investment**

---

### Primary Modernization

In FY11 Base Budget—30 fewer positions                      \$1,950,000 gross

### Child Care Addition

In FY11 Proposed Budget effective 1/31/11                      200,000 GF

Challenges for Change effective 1/31/11                              100,000 GF

Estimated Savings in FY12    500,000 GF

## **Changes Needed in Statute and Regulation**

---

None

## **Timeline for Implementation**

---

Full Economic Services implementation 6/1/10

Implementation of Child Care Eligibility 1/31/11

## **Investments Needed**

---

One Time IT investment to:

- 1.) Create data sharing between the ESD ACCESS system and the CDD Bright Futures Information System (BFIS).
- 2.) Make changes within each system to accommodate the data.
- 3.) Update the ESD Modernization process.
- 4.) Update the ESD Notice system.

Total estimated cost(s) \$150,000

## **Information Technology (IT) Needs**

---

See Above

## **Stakeholder Involvement**

---

- Extensive meetings with advocates, consumers, partners and staff over a two year period related to the large modernization effort.
- Several meetings with Community Child Care Service Providers.
- Overview for other early childhood providers and advocates.
- There will be extensive ongoing work with providers who will be directly affected.

# Improved Child Support Collections Challenges for Change

## Executive Summary

---

In any given month approximately 25% of child support cases have noncustodial parents fail to make even a single child support payment resulting in \$18,000,000 per year accruing in unpaid child support. Additionally, thousands of noncustodial parents are making no medical support contributions for their children who are receiving Medicaid despite having the ability to do so. A package of statutory changes and related resources could significantly improve these outcomes. Specifically,

- Tighten existing New Hire Reporting laws to shorten the reporting window, improve compliance by employers, and address the problem of “self employed” employees who are characterized as “subcontractors”. To the extent this information is also used by other divisions that need income and employment verification this should also reduce improper payments by those divisions. This project would involve working with the Department of Labor to develop a plan for implementation.
- Amend existing license suspension statutes to permit administrative suspension and expand the scope to include nonrenewal of vehicle registrations. This would require working with the Department of Motor Vehicles to develop a process for implementation.
- Update the state’s criminal nonsupport statutes to clarify the penalties for nonsupport and provide OCS attorneys concurrent jurisdiction to prosecute these cases.
- Amend existing statutes to require a cash medical contribution in Medicaid cases where the parents cannot provide for private coverage at a reasonable cost.

## Outcome/Indicators

---

*Children live in safe, nurturing, stable, and supported families.*

- Percent of child support cases with collections.
- Increase in child support collections (\$) to families and to offset TANF Expenditures.

*Vermonters receive affordable and appropriate health care at the appropriate time, and health care costs are contained over time.*

- Increase in cash medical support (\$) that offsets Medicaid expenditures.

## Estimated Savings and Return on Investment

---

With the investments noted below, the following earnings/savings can be conservatively expected in FY12:

Revenue earnings for families	\$675,000
GF gains for the state	\$347,730GF (including cost avoidance)
Revenue returned to the feds	\$410,220
 Total gains:	 \$1,432,950

Net GF Savings (after investments below)	\$238,280
GF Savings in FY'11 would be $\frac{3}{4}$ of this amount	\$178,710

### **Changes Needed in Statute and Regulation**

---

- Statutory changes are needed to implement all four of these initiatives.

### **Timeline for Planning and Implementation**

---

- New Hire Reporting - It is necessary to work with DOL during the upcoming year. Estimated implementation (assuming no major I.T. changes are necessary is January 2011.
- License, registration, and criminal procedures - It is necessary to work with DMV for this new project. This would require I.T. support, as well as ramping up staffing. Earliest full implementation July 1, 2012.
- Cash Medical Contributions - This process can start immediately, if legislative wording changes and we work our existing cases. If, however, OCS were to assume more cases, which would include significant programming and staff ramp up time, the implementation could be October, 2010.

### **Investments Needed**

---

Note: all investments and IT are reimbursed at 66% IV-D Match Rate

Four FTEs are needed to implement these strategies:

- New Hire Reporting – 1 FTE
- License, registration, and criminal procedures – 1 FTE's (FY'12)
- Cash Medical Contributions – 2 FTE's

FY'11 GF Cost of 3 FTEs \$72,270  
 One-Time IT Investments \$80,000

FY'12 Cost (4 FTEs) \$96,360

### **Information Technology (IT) Needs**

---

- New Hire Reporting - Additional programming for monitoring reporting and ongoing maintenance
- License, registration, and criminal procedures - Additional programming for interfaces as well as ongoing maintenance
- Cash Medical Contributions - If simple legislative word changes, none. (This assumes currently pending related IT work will be done by then.)

### **Stakeholder Involvement**

---

- New Hire Reporting – We have been discussing this with DOL and would work with them on this.

- License, registration, and criminal procedures – We will need to discuss this with DMV, States Attorneys, and the Court Administrator.
- Cash Medical Contributions – The House Health and Welfare Committee has expressed interest in pursuing this.



# Challenges for Change

- Expansion of the Blueprint for Health
- Office of Vermont Health Access (OVHA)
  - Direct Care Coordination Expansion
  - Clinical Utilization Review Board

# **Statewide Expansion Blueprint Coordinated Health Systems Challenges for Change**

## **Executive Summary**

---

Vermont's Blueprint for Health is a highly coordinated, systemic approach to health, wellness, disease prevention, and care coordination. The Blueprint, which has implemented delivery system transformation with Integrated Health Services Pilots in three communities, is poised to expand in multiple dimensions. First, over the course of the next three years, the Patient Centered Medical Homes (PCMHs) – supported by Community Health Teams (CHTs) and a health information technology infrastructure – will expand to primary care and pediatric practices in Hospital Service Areas statewide. Second, the Community Health Teams that support guideline based care, population reporting, and coordination of care and services through health information exchange, will dramatically expand their integration with state and community based public health and human service programs. Just as the PCMH serves as the focal point for patient health care, the expanded CHT connectivity with Agency staff and AHS contractors will ensure more comprehensive integration of and communication with health and human services providers and programs.

The functional Community Health Teams will form a bridge between AHS clients' Patient Centered Medical Homes and the Agency's human services programs. While the Blueprint itself is focused on the total population, the new links that will be implemented in connection with multiple Challenges initiatives will help integrate specific sub-populations and programs, such as those associated with the Department of Health (VDH), Department of Mental Health (DMH), Department for Children and Families (DCF), and the Office of Vermont Health Access (OVHA) in the broader Blueprint delivery system reform.

As an example, Vermont Medicaid is expanding the capacity of community health teams with care coordinators that will work with high risk patients to improve control of chronic conditions and prevent avoidable hospitalizations. Similar planning is underway for extension of the model to include Pediatrics and family wellness, coordinated care for high risk seniors, and coordination between healthcare and public health prevention programs. The program's guiding principles are being applied in each case with investment in preventive community based outpatient services, an emphasis on enhanced self management and healthy behaviors, and financial sustainability based on reductions in avoidable expenditures for poorly controlled health conditions.

In another example, planning is underway to establish Mental Health & Substance Use Medical Homes with similar financial reforms that can support high quality outpatient services and preventive care, with reductions in avoidable acute care expenditures. This would establish a continuum of mental health and substance use services for patients. They would receive better screening and counseling for lower acuity needs provided by their primary care medical home and community health team. Patients with higher level need would have coordinated referrals to specialty services in the mental health and substance use medical home.

The Blueprint model is designed to be sustainable, scalable, and adaptable to variable practice sizes and settings, and it is supported by a health information and evaluation infrastructure. This IT infrastructure includes data sources to evaluate the clinical and financial impacts of the model. Routine reporting provides a basis for ongoing quality improvement and planning for statewide expansion. Many of the Agency's Challenges initiatives will be able to leverage the Blueprint data and evaluation infrastructure to integrate performance measures across the Agency focused on specific programs and populations.

Currently, the CHTs include members such as nurse coordinators, social workers, and behavioral health counselors who provide support and work closely with clinicians and patients at a local level. Services include individual care coordination, outreach and population management, counseling, and close integration with other social and economic support services in the community. This high level of care incorporates strategies to enhance self management and is designed to integrate with community-wide prevention efforts guided by Public Health Specialists that are part of the CHT. As the Agency programs become more integrated and patient-centered, the CHT's will become venues in communities for making connections between programs, providers, and the populations they serve.

Two key ingredients are essential for full statewide Blueprint expansion:

1. Commercial insurers and Vermont Medicaid need to agree to a plan for expanding the payment reform model that supports medical homes and community health teams across the state.
2. Medicare participation must be obtained.

The first component is being addressed: Medicaid is committed to the expansion strategy and legislation pending in the House Human Services Committee (H.627) will ensure the participation of Vermont's commercial insurance carriers.

As for the second, U.S. Department of Health and Human Services Secretary Kathleen Sebelius announced Medicare's plans to participate with state led multi-insurer reform as part of an Advanced Model of Primary Care Demonstration Program in September 2009. Application guidance for the Demonstration Program is expected to be released by CMS imminently.

### **Initiative**

- a) Conduct readiness work in HSAs across Vermont that prepares communities to implement the Blueprint Integrated Health Services Model.
- b) Readiness work includes training and preparation for practices to operate as patient centered medical homes, design and implementation of community health team operations, and set up of a supportive health information infrastructure with data transmission from hospitals and practices to a centralized registry.
- c) FY11: The Blueprint will adjust its budget to support statewide implementation and expansion. This includes HSA grants and expansion of the Blueprint team. The Blueprint team will include facilitators who can provide on the ground support for planning and implementation in each HSA, practice transformation to operate as medical homes supported by community health teams, and data-guided ongoing quality improvement.
- d) Statewide expansion of the Blueprint model with a goal of establishing medical home and community health team operations in all HSAs by July 2011 and expansion to 80% of Vermont's population by July 2012.

- e) A process of structured evaluation of the health and financial impacts of the Blueprint model, with ongoing adjustments designed to result in a refined model of integrated health services.

Expansion of the Integrated Health Services Model across Vermont- The Blueprint Integrated Health Services (IHS) model is designed to improve the health of the population, and improve control over escalating healthcare costs. Pilots have been implemented in 3 Hospital Service Areas (HSAs) that include multi-insurer payment reform, medical homes supported by community health teams (CHTs), expanded use of health information technology, and an evaluation infrastructure designed to determine program impact and guide ongoing quality improvement.

The Blueprint model starts with a relatively comprehensive approach that will support an advanced model of primary care, establishing a foundation for broader restructuring of healthcare delivery. Multi-insurer payment reform, which supports medical homes and community health teams, has stimulated interest among providers across Vermont and set the stage for statewide expansion. This interest extends beyond the natural attraction that would be expected for primary care providers to include hospitals. Multi-insurer payment reform means that hospitals can re-examine how they look at primary care, which has traditionally been difficult to support financially due to low fee for service reimbursement.

With adequate financial support, hospitals can consider expanding primary care networks in their HSA and may even consider a transition towards a business model that begins to balance primary care, specialty care, and acute care resources based on a community need. To date, high reimbursement rates for acute care and specialty care has led hospitals to emphasize these services, while low reimbursement has de-emphasized preventive services. The Blueprint model has initiated a shift with insurers investing in primary care and prevention, providing an opportunity for providers to recalibrate their predictable emphasis on well-reimbursed services for people who are already sick.

Financial Support for Expansion- The Vermont Association of Hospitals and Health Systems (VAHHS) Board unanimously supported a motion that all acute care hospitals would provide strong leadership in their community to expand the Blueprint Integrated Health Services Model into all hospital service areas by July 2010. VAHHS supported efforts to add funds to the state budget to support Blueprint expansion statewide, reflecting the commitment to utilizing the Blueprint for substantive transformation of our health care delivery and payment system. The FY10 appropriation is being used to support medical home and community health team preparations statewide.

Expansion of payment reform requires participation of Vermont's insurers, and ideally the participation of Medicare as part of multi-insurer payment reform. Active negotiations and planning is underway for these steps. The readiness work in each HSA will allow a faster and more efficient roll out of the model should insurers agree to expansion. The goal is to establish a set of primary care practices in each HSA that are ready to operate as medical homes, with plans in place for a local CHT, better coordination across existing community services, and a health information infrastructure that supports well coordinated care and panel management. Given Vermont's healthcare landscape, and the experience with the Integrated Pilots, the best route to achieve these goals is to work closely with hospitals and practices in each HSA to establish

operations. The steps that are involved to set up medical home and community health team operations are outlined.

- Conduct presentations and discussion sessions with key stakeholders in each HSA. These sessions include hospital administrators, primary care providers, other clinicians such as care coordinators and social workers, local public health personnel, and information technology personnel. Participants are provided an opportunity for detailed understanding of the Blueprint model. With this information, the local stakeholders can identify the participants for planning and implementation of the model. The number of presentations and meeting sessions may vary in each community in order to build consensus, momentum, and understanding.
- Identify a select number of primary care practices in each HSA to participate. The number of practices in each HSA varies and may depend on a number of complex cultural and business issues including; whether a practice is affiliated with a hospital or other organization with administrative and technical support, whether the clinicians feel overwhelmed by their work load, whether the clinicians are cautious regarding substantive change and want to see how things progress in other practices, or whether a practice is already in the middle of significant change such as implementing an electronic medical record.
- Identify key personnel for two parallel planning and work processes. This includes planning and implementation of the health information infrastructure. It also includes planning for PCMH and CHT operations. For each of these processes, planning is likely to include lead contacts from the hospital, practices, local public health office, and other service organizations.
- Health information infrastructure work includes;
  - Identify important data sources in the practices and hospital that should be integrated through the VITL / GE health information exchange (e.g. practices' EMRs and hospital data sources).
  - Map existing EMRs and data sources against core Blueprint data elements (Health Maintenance & Prevention, Asthma, Diabetes, HTN)
  - Update EMRs against core data elements and answer options to assure structured data entry for key measures that will be used for individual patient care, population management, and program evaluation.
  - Practices that do not have an EMR will be provided licenses to use DocSite directly to support individual patient care
  - Develop interfaces between practices, hospitals, and VITL / GE health information exchange
  - Establish data transmission of core Blueprint measures from data sources through VITL / GE to DocSite
  - Conduct quality testing on transmitted data and reports generated
  - Establish functional DocSite reporting that works across organizations and clinical tracking systems.

- Clinical and health services work includes;
  - Clinicians participate in learning collaboratives and practice transformation training that is aligned with NCQA PPC-PCMH standards
  - Identify existing personnel in the community who can work and coordinate with the core CHT that will be supported by payment reform.
  - Identify what staffing and skills are needed for the core CHT
  - Identify and establish planning contacts with key service organizations in the community that will coordinate with the CHT
  - Plan clinical operations for the new Community Health Team (new personnel + existing personnel) that will provide care support for primary care practices
  - Plan referral and population management priorities for medical homes, CHT, and public health services.
  - Plan coordination with other services, including public health, economic support and social services
  - Plan administrative structure for managing enhanced payment to practices and funding for CHTs
  - Participate in training to use centralized registry for reporting, panel management, and quality improvement

In each HSA, the number of practice sites that are involved, the size of the population served, and the IT development work will vary. A project plan to accomplish the steps outlined above is to be developed in each HSA.

As the Blueprint Integrated model (including payment reform) expands, each participating practice is scored against NCQA PPC-PCMH standards. These scores are used to guide quality based payment and to plan quality improvement. Insurers will attribute patients to the participating practices and their medical claims data will be flagged in the multi-insurer claims database.

Advantages & Risks for Participants in each HSA- There are several advantages to each HSA for establishing PCMH and CHT readiness. First, operable population based reporting and care coordination will improve outpatient preventive care, and begin a cultural transition towards structured guideline based processes. Second, having these clinical operations in place provides a better opportunity to realize gain in any gain-risk sharing financial arrangement such as global budgets or an Accountable Care Organization. Third, these preparations, with a clinical and information infrastructure, position each HSA to more rapidly implement full PCMH and CHT operations if payment reform expands to their area.

It is important to note that working with the Blueprint to establish medical home and CHT readiness does not assure that payment reform will expand to each HSA. The risks taken by each HSA are the local investments made in order to accomplish PCMH and CHT readiness. These risks are real but mitigated because the Blueprint and Vermont Information Technology Leaders (VITL) are sharing costs and supporting most direct expenditures for readiness work. The major cost for participants in each HSA is the time commitment. Participants need to balance this commitment to readiness work, and the uncertainty of insurers expanding payment reform,

against the current trends in national healthcare reform policy, and the growing engagement in this model by some of our commercial insurers and Vermont Medicaid.

Financial support for readiness work- The currently planned shared cost structure for readiness expansion includes the Blueprint supporting health information technology enhancements and interfaces for clinical practice sites, costs for the DocSite clinical tracking and reporting system, training and support for the DocSite system, and, training and facilitator support for medical home readiness and practice transformation. VITL is supporting costs for development and operation of the health information exchange including the HIE side of interfaces, and overall health IT project management in each community. Local costs will include a care coordinator dedicated to a select group of primary care practices. This care coordinator will work with existing care support personnel, public health personnel, and existing social and community services to improve overall integration of services for primary care populations (the so-called “CHT lite”). The planned cost structure for health IT may change depending on availability of Federal support through the American Reinvestment and Recovery Act (ARRA). In each community, the Blueprint, VITL, the local hospital, and participating practices will develop a budget plan for the HSA specific circumstances.

Expansion of payment reform across Vermont is linked to a couple of key advancements. First, the commercial insurers and Medicaid must agree to expand, either on their own or in conjunction with Federal participation. Second, the Federal Government (in particular Medicare) must participate as part of a state led multi insurer initiative. Currently, progress is being made on both fronts. Vermont’s substantial health reforms, and the Blueprint Integrated Health Services model, have attracted great interest across Vermont, other states, and as part of the national healthcare reform discussion in Washington, DC. On September 16, 2009, Health and Human Services (HHS) Secretary Kathleen Sebelius announced the launch of a new (to be fully defined by HHS) Medicare demonstration project for "an initiative that will allow Medicare to join Medicaid, and private insurers in state-based efforts to improve the way health care is delivered." <http://www.hhs.gov/news/press/2009pres/09/20090916a.html> This Advanced Model of Primary Care demonstration project's specific design is still to be defined, and states (including Vermont) have to apply to be a demonstration project state once the guidance is published. The more specific Fact Sheet that was embedded in the HHS press release can be found at: <http://healthreform.gov/newsroom/factsheet/medicalhomes.html>. The hope is that this demonstration project will provide an opportunity to engage Medicare as part of multi-insurer payment reform in Vermont. HHS has stated that they are working towards a rapid implementation cycle for this demonstration project.

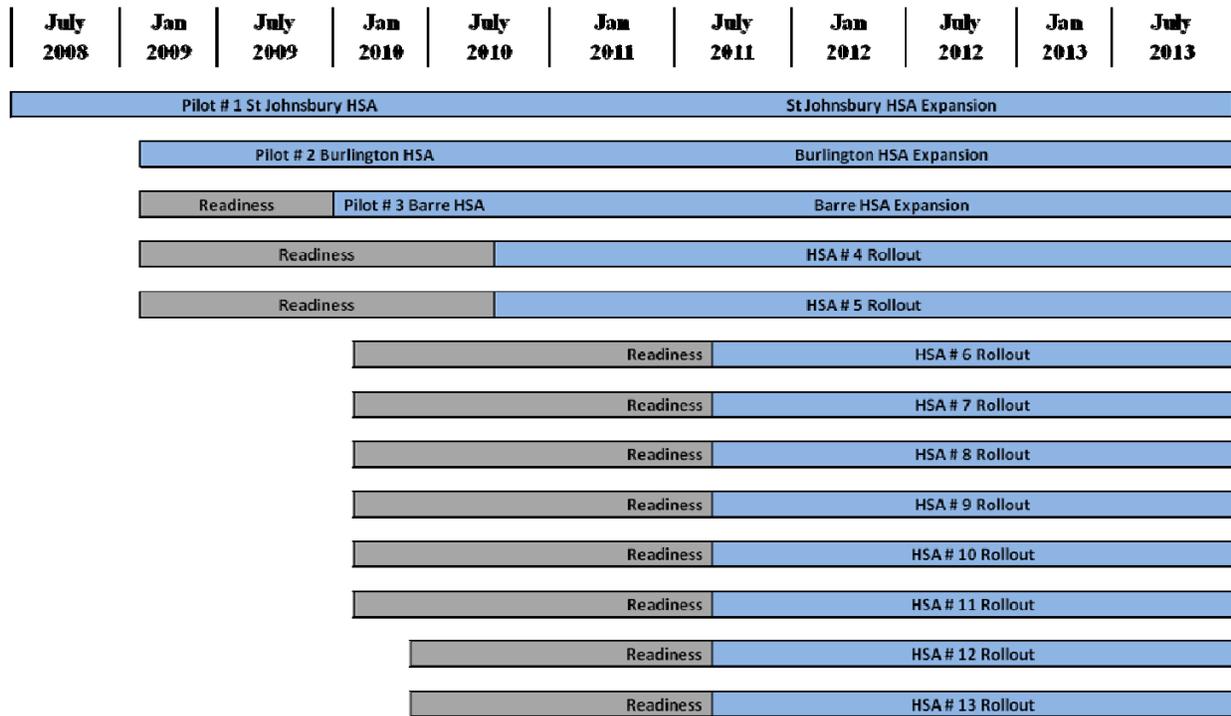
The opportunity offered by the HHS announcement, and Medicare participating as part of multi-insurer reform, has provided an impetus for the Blueprint to work with Vermont’s commercial insurers and Medicaid to consider an accelerated time cycle for statewide expansion. The Blueprint is currently in active discussions regarding a plan for expansion. Two competing lines of thought have dominated the discussions. First is the desire to see outcomes data that supports a decision for insurers to invest in statewide expansion. Second is the understanding that shifting their expenditures from disease management contracts to local CHTs will in part offset the insurers’ investment in the model. This important offset cannot be realized until enough of the population is involved allowing insurers to end their disease management contracts and shift

their expenditures. These two competing priorities present a situation where either the insurers don't expand until sufficient outcome data is available, or expansion moves ahead regardless in order to take advantage of the financial offset and the ability for an expanded program to more rapidly support a robust evaluation of clinical and financial outcomes.

Proposed Timeline for Statewide Expansion- The Blueprint is currently proposing a plan to expand the Integrated Health Services Model to 5 Hospital Service Areas by July 2010, and to all HSAs by July 2011. The proposed timeline also includes steady expansion within each HSA to include providers and populations that weren't part of the first 3 pilot programs. This proposal may need to be adjusted based on the timeline for Medicare participation, should Vermont be selected as one of the Advanced Model of Primary Care demonstration sites. However, it is also possible for expansion to occur without Medicare participation. For this to occur, providers would need to accept payment reform that doesn't include Medicare's portion.

The current proposal includes several important adjustments to what was initially planned for the pilot program. The first 3 pilots were going to operate for a minimum of two years each, with a subsequent decision for expansion. The current proposal considers the work to date as an implementation phase, with a transition to a demonstration phase that aligns with the Federal demonstration program. This embeds five years of experience, with the ability to evaluate clinical and financial impacts on a statewide basis. This amount of time for operations to mature, along with the Blueprint's robust evaluation framework and data sources, will provide an extraordinary opportunity to determine the impact of the model. It is important to note that the model will not remain static. The evaluation framework is designed so that routine reporting and comparative benchmarks provide a basis to guide ongoing quality improvement. The proposed expansion is designed to result in a highly refined model of Integrated Health Services.

## Blueprint Integrated Health Services Model - Proposed Timeline for Expansion



Implementation Phase	Demonstration Phase (Medicare?)				
<b>Target Population</b>	<b>42,179</b>	<b>126,286</b>	<b>316,662</b>	<b>508,17</b>	<b>637,130</b>
<b>% of VT Population</b>	<b>6.7%</b>	<b>20%</b>	<b>50%</b>	<b>80%</b>	<b>100%</b>
<b># CHTs</b>	<b>2</b>	<b>6</b>	<b>16</b>	<b>25</b>	<b>32</b>

## Outcome and Indicators

Statewide expansion of the Blueprint Integrated Model has the following advantages:

- A statewide primary care foundation of patient centered medical homes and community health teams, supported by multi-insurer payment reforms that begin to align financial incentives and healthcare goals.
- Coordinated care for patients and families across a continuum that includes; primary care practices, community health teams, specialty care, and improved linkages to a broad range of social and economic support services.
- Increasing the rate that patients receive recommended health maintenance and preventive assessments, and guideline based care for established conditions.
- A healthcare infrastructure and culture oriented towards prevention, healthy lifestyles, and enhanced self management.
- A statewide foundation of medical homes and community health teams designed to result in a reduction in avoidable hospitalizations and emergency care visits thru improved engagement of patients in preventive care, improved transitional care from hospitals and emergency rooms to preventive care, and, targeted disease management programs.

- Improved control over growing healthcare costs despite new investments in medical homes and community health teams thru a reduction in avoidable acute care expenditures, and a shift in expenditures from contracted disease management services to local community health teams.

Based on the above, the Challenges for Change Outcomes that will be addressed include:

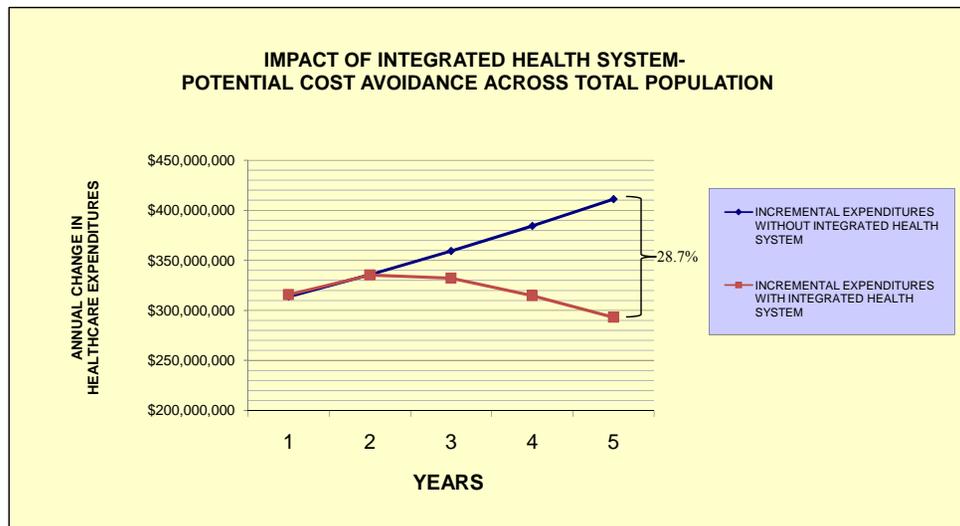
- Individuals and families will better direct their own lives and will be supported in pursuing their own choices, goals, aspirations, and preferences
- The individual will be at the core of all plans and services and will be treated with dignity and respect
- Individuals and families with multiple needs will have coordinated services with a single point of accountability to manage services
- Adults lead healthy and productive lives
- Vermonters receive affordable and appropriate health care at the appropriate time, and health care costs are contained over time

The Blueprint will conduct a comprehensive evaluation of the program's success at improving clinical and utilization outcomes using administrative (claims) data supplemented with information on clinical quality metrics and health status measures. In FY11, the Blueprint anticipates that there will be a 12% reduction in inpatient admissions and a 13% reduction in emergency room (ER) visits for patient populations receiving care in the Blueprint Integrated Health Services model. In CY12, the Blueprint anticipates a changing trend with a reduction in the rate that overall healthcare expenditures are growing in the state of Vermont. This expectation is predicated on expansion to a sufficient portion of Vermont's population, a reduction in avoidable hospitalizations and emergency department visits, and insurers shifting expenditures from contracted disease management programs to local community health teams. Predictions were arrived at using the Blueprint business model for costs savings and reduction in utilization.

## Savings

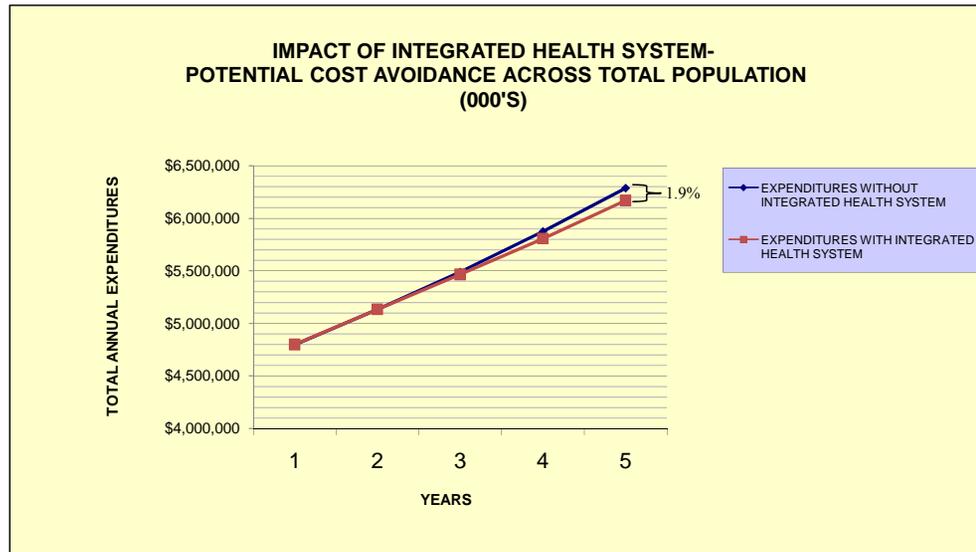
Utilizing estimates from the Blueprint business model, if program expansion occurs as proposed the model projects that in CY 2011 the annual growth of healthcare expenditures in Vermont will be reduced by \$26,923,428, and in CY 2012 the annual growth of healthcare expenditures will be reduced by \$69,630,923.

However, the Blueprint will conduct an analysis of healthcare expenditure patterns in CY 2011 with appropriate adjustment of the business model to more accurately project CY 2012 financial impact.



Target Population	42,179	126,286	316,662	508,17	637,130
% of VT Population	6.7%	20%	50%	80%	100%
# CHTs	2	6	16	25	32

3/21/2010



<b>Target Population</b>	<b>42,179</b>	<b>126,286</b>	<b>316,662</b>	<b>508,17</b>	<b>637,130</b>
<b>% of VT Population</b>	<b>6.7%</b>	<b>20%</b>	<b>50%</b>	<b>80%</b>	<b>100%</b>
<b># CHIs</b>	<b>2</b>	<b>6</b>	<b>16</b>	<b>25</b>	<b>32</b>

22

It is important to note that integration of the Blueprint model with Medicaid, Mental Health and Substance Use, Children’s Services, and high risk senior groups, will lead to further opportunities for reduced healthcare expenditures. Planning for integration across the broad range of human services is underway (see executive summary) including the development of financial models that will determine the potential for further savings.

## **Changes Needed in Statute and Regulation**

---

For the Blueprint to expand multi-insurer payment reform statewide, it will be necessary to require commercial insurers to participate. Legislation is pending in the House Health Care Committee (H.627) will amend previous language (Act 204, 2008) that required commercial insurers to participate in the currently operating Blueprint Integrated Pilots to require participation in the expansion detailed above.

## **Timeline for Planning and Implementation**

---

Hire (contract with) and train Blueprint facilitators for a July 1, 2010 implementation date. Hire 2 new core Blueprint team members.

## **Investments Needed**

---

Two new core Blueprint team members (State employees). Eight new facilitator-coaching positions (most likely contracted positions).

- SFY 2011: Level funded budget that shifts expenditures from Blueprint Community Grants to HSA grants, adds two State employees to the core Blueprint team, and supports eight facilitators/coaches (contracted positions).

## **Information Technology (IT) Needs**

---

Expansion of health information infrastructure that includes data transmission from EMRs and hospitals to the Blueprints web-based centralized registry (DocSite).

- Medical home practices and Community Health Team members (including OVHA CCs) have access to DocSite to support patient care, care coordination, panel management, and patient outreach.
- Updates to EMRs to include core data elements for health maintenance, prevention, and chronic disease.
- Updates to DocSite are in progress to support tracking of CHT care coordination activities, pediatrics, and other targeted health conditions.

## **Stakeholder Involvement**

---

The Blueprint consistently engages a broad range of key stakeholders in planning and implementation of the integrated health services model thru its Executive Committee, Planning & Evaluation Committee, and Physician Advisory Committee. Broader local stakeholder engagement is inherent in the design of the integrated health services model. In each community, program leaders work with local stakeholders to design their Community Health Team, plan clinical operations, and assure linkages with a broad range of social and economic services. In this way the Blueprint is leading a process of transformation guided by a strong state level commitment, while assuring that respect for local expertise leads the design and coordination of services, and engagement with a broad array of community based services. The Blueprint has worked closely with OVHA leadership on this expansion proposal to assure that OVHA care coordinators become a fully integrated part of the Community Health Teams. Collaboration with the University of Vermont's medical informatics program will provide additional resources for sophisticated data analysis and evaluation of the program.

# OVHA Direct Care Coordination Expansion Challenges for Change

## Executive Summary

---

The Office of Vermont Health Access (OVHA) wants to expand our direct care coordination capacity so we can improve the health care and outcomes for our beneficiaries with significant medical needs in two areas of our state as an initial trial. We believe this coordination will reduce OVHA's health care costs as well as improving medical outcomes.

As background, in 2007 OVHA implemented a statewide Chronic Care Initiative (CCI) for Medicaid beneficiaries who have chronic health conditions that result in high health costs, high medication utilization, and/or high preventable emergency room and inpatient utilization. The CCI is a holistic approach; it addresses physical, behavioral, and socioeconomic conditions that present barriers to health improvement. The CCI is tiered with intervention services along a continuum from printed education and self-management information for lower risk beneficiaries, to telephonic disease management services for those at moderate risk, to intensive face-to-face care coordination of medical and social services for the most costly and medically complex beneficiaries. OVHA's existing 12 care coordination staff, spread across 8 districts to provide a statewide presence, performs the intensive face-face case management services and APS contract staff provides predominantly telephonic disease management services.

The OVHA CCI goals and objectives fully align with Vermont healthcare reforms. For example, the OVHA CCI staff work with the Blueprint Community Health Teams (CHT's) to foster adherence to clinical best practices and lower health care expenditures for chronic conditions in partnership with the primary care physicians. Specifically, the existing OVHA CCI staff located in the three Blueprint integrated pilot sites function as core members of the Blueprint CHT's, and explicitly address the needs of the Medicaid beneficiaries with complex needs. This *Challenges for Change* Initiative will add three new OVHA direct care coordination staff in two additional areas of the state (a total of 6 new staff) with high Medicaid beneficiary needs. In addition to providing better care for beneficiaries, it also will enhance "Blueprint readiness work" in these locations.

## Initiative

- f) Use geographic distribution of Medicaid population and financial modeling to identify two high utilization, high penetration hospital service areas to enhance OVHA's current presence by adding on-site OVHA direct care coordination staff in each of two areas in FY11 (*Preliminary locations are Rutland and Franklin counties*)
  - Composition: New on-site staff will consist of 1 RN and 2 licensed clinical social workers for each of the two areas. The six additional OVHA staff will expand upon the work of the existing CCI staff in those areas
- g) FY11: Divert approximately \$500,000 in funds from current APS Healthcare Disease management contract to fund teams
- h) Formally evaluate the effectiveness of new OVHA staff and, if successful, fully transition away from telephonic disease management to statewide OVHA direct care coordination staff by FY12

These new OVHA care coordination staff will work closely with existing OVHA CCI staff in the field to harmonize with other personnel and services in the community, establishing a functional beneficiary support network that is much larger than the proposed new 6 full-time employees (FTEs). The model is designed to be sustainable, scalable, and adaptable for all practice sizes, from rural to urban settings.

## **Outcome and Indicators**

---

Positioning new Medicaid direct care coordination staff in two additional communities has the following service delivery advantages:

- Further integrates Medicaid chronic care initiative with Blueprint financial reform and establishment of patient-centered medical homes (PCMH)
- Accelerates Blueprint “readiness work” in the two Hospital Service Areas (HSA)
- Assists practitioners in preparing for Blueprint’s National Committee for Quality Assurance (NCQA) PCMH accreditation
- Improves beneficiaries’ ability to self-manage through closer on-site collaboration with the physician and community
- Phases out telephonic services and expands face-to-face support resulting in a lower per member per month (PMPM) cost
- Provides greater integration at community level, establishing a functional care support team that is much larger than the proposed 6 FTEs
- Enables faster and more efficient support to Primary Care Physicians (PCPs )
- Intervenes on a larger scale as staff time locating beneficiaries is diminished
- Expands Blueprint model to include Medicaid children

Based on the above, the Challenges for Change Outcomes that will be addressed include:

- Individuals and families will better direct their own lives and will be supported in pursuing their own choices, goals, aspirations, and preferences
- The individual will be at the core of all plans and services and will be treated with dignity and respect
- Individuals and families with multiple needs will have coordinated services with a single point of accountability to manage services
- Adults lead healthy and productive lives
- Vermonters receive affordable and appropriate health care at the appropriate time, and health care costs are contained over time

OVHA will conduct a comprehensive evaluation of the program’s success at improving clinical and utilization outcomes using administrative (claims) data supplemented with information on clinical quality metrics obtained through medical records reviews. Specific indicators include:

- reduction in unnecessary inpatient admissions
- reduction in unnecessary emergency room (ER) use
- increased consumer satisfaction, as measured by the annual Consumer Assessment of Health Plan Satisfaction) (CAHPS) survey

## **Savings**

---

Utilizing the Blueprint business model for savings, OVHA has projected a \$652,000 net additional savings for FY11 by adding these six (6) additional staff. It is anticipated that the

FY12 savings will be significantly higher than the FY11 net savings. Prior to formalizing those projections, OVHA will have an independent third party analyze the effectiveness of the pilot project. The analysis also will help determine the future direction of the APS contract.

## **Changes Needed in Statute and Regulation**

---

In order to give OVHA more flexibility to alter the Chronic Care Initiative program as we examine the effectiveness of the direct care coordination staff expansion, Section 6 of 33 VSA §1903a should be amended to remove language requiring that a private entity administer the program. The specific changes needed are as follows:

### **§ 1903a. Chronic care management program**

(a) The secretary of administration or designee shall create a chronic care management program as provided for in this section, ~~which shall be administered or provided by a private entity~~ for individuals with one or more chronic conditions who are enrolled in Medicaid, the Vermont health access plan (VHAP), or Dr. Dynasaur. The program shall not include individuals who are also eligible for Medicare, who are enrolled in the Choices for Care Medicaid Section 1115 waiver or who are in an institute for mental disease as defined in 42 C.F.R. § 435.1009. The secretary may also exclude individuals who are eligible for or participating in the Medicaid care coordination program established through the office of Vermont health access.

(b) The secretary shall include a broad range of chronic conditions in the chronic care management program.

(c) The chronic care management program shall be designed to include:

(1) a method involving the health care professional in identifying eligible patients, including the use of the chronic care information system established in section 702 of Title 18, an enrollment process which provides incentives and strategies for maximum patient participation, and a standard statewide health risk assessment for each individual;

(2) the process for coordinating care among health care professionals;

(3) the methods of increasing communications among health care professionals and patients, including patient education, self-management, and follow-up plans;

(4) ~~the educational, wellness, and clinical management protocols and tools used by the care management organization,~~ including management guideline materials for health care professionals to assist in patient-specific recommendations;

(5) process and outcome measures to provide performance feedback for health care professionals and information on the quality of care, including patient satisfaction and health status outcomes;

(6) payment methodologies to align reimbursements and create financial incentives and rewards for health care professionals to establish management systems for chronic conditions, to improve health outcomes, and to improve the quality of care, including case management fees, pay for performance, payment for technical support and data entry associated with patient registries, the

cost of staff coordination within a medical practice, and any reduction in a health care professional's productivity;

~~(7) payment to the care management organization which would put all or a portion of the care management organization's fee at risk if the management is not successful in reducing costs to the state;~~

(8) a requirement that the data on enrollees be shared, to the extent allowable under federal law, with the secretary in order to inform the health care reform initiatives under section 2222a of Title 3;

~~(9) a method for the care management organization to~~ Close participation ~~closely~~ in the blueprint for health and other health care reform initiatives; and

(10) participation in the pharmacy best practices and cost-control program under subchapter 5 of chapter 19 of this title, including the multi-state purchasing pool and the statewide preferred drug list.

~~(d) The secretary shall issue a request for proposals for the program established under this section and shall review the request for proposals with the commission on health care reform prior to issuance. The issuance of the request for proposals is conditioned on the approval of the commission in order to ensure that the request meets the intent of this section, section 702 of Title 18, and chapter 19 of this title. Any contract under this section may allow the entity to subcontract some services to other entities if it is cost effective, efficient, or in the best interest of the individuals enrolled in the program.~~

(e) The secretary shall ensure that the chronic care management program is modified over time to comply with the Vermont blueprint for health strategic plan and to the extent feasible, collaborate in its initiatives.

(f) The terms used in this section shall have the meanings defined in section 701 of Title 18. (Added 2005, No. 191 (Adj. Sess.), § 6; amended 2007, No. 70, §§ 22, 23.)

## **Timeline for Planning and Implementation**

---

Hire and train new teams for a July 1, 2010 implementation date.

## **Investments Needed**

---

Six new state positions

- FY11: Divert \$ 500,000 in funds from current APS Healthcare Disease Management contract to fund new direct care coordination staff.
- FY12 and beyond: If successful, use entire APS contract funds to support statewide enhanced OVHA direct care coordination staff and BP health teams (CHT) and provider incentives.

## **Information Technology (IT) Needs**

---

The new OVHA direct care coordination staff will use Blueprint's DocSite:

- DocSite is a web-based patient registry and point of care decision support system that stores and tracks key quality and care improvement information on patients. Additionally, it has the capability to report information for purposes of population measurement, quality of care improvement and identification of patients whose care may require better coordination and management.
- OVHA's existing Care Coordinators already have access to DocSite for administrative claims data
- HP, OVHA's fiscal agent, will provide DocSite with monthly eligibility and claims data
- Care Coordination data elements and care plans already integrated into DocSite

## **Stakeholder Involvement**

---

OVHA CCI has engaged in outreach and collaboration with other internal and external agencies, stakeholders, providers and healthcare system entities statewide since its inception in 2006. These efforts have included, but are not limited to, other AHS departments and divisions and other agencies, regional mental health services and substance abuse treatment providers, homeless shelters; hospitals and provider practices, the University of Vermont School of Medicine, Area Health Education Centers; and other healthcare-related associations (e.g., Vermont State Nurses Association, Visiting Nurses Association, etc.).

OVHA has been working closely with Blueprint leadership on this expansion proposal; and, if it is approved, Blueprint and OVHA senior managers will jointly reach out to the two HSAs and fully imbed the OVHA enhanced care coordination capacity in these communities and help them prepare for NCQA certification as a PCMH.

Lastly, OVHA will present the redesign to the Medicaid Advisory Board at the next available meeting.

# OVHA Clinical Utilization Review Board Challenges for Change

## Executive Summary

---

The Office of Vermont Health Access (OVHA) must ensure that medical treatments and services paid for with state health care dollars are safe and clinically effective. Ultimately, the goal is to provide coverage for evidence-based care that meets the specific needs of our beneficiaries in the most cost-effective manner.

Nationally and in Vermont, health care costs are rising at an unsustainable rate. The cost of healthcare in Vermont is estimated to increase by \$1 billion from \$4.9 billion to \$5.9 billion by 2012. Factors that influence increased costs in Vermont Medicaid programs include under and over utilization of services and inappropriate use and over-use of new technology.

As such, OVHA proposes to establish an Independent Clinical Utilization Review Board (CURB) to examine current medical services and emerging technologies and make recommendations to OVHA regarding coverage, unit limitations, place of service, and appropriate medical necessity of services. OVHA currently uses these clinical care management approaches much less than commercial insurers, and many other state Medicaid programs that contract with traditional Managed Care Organizations (MCO) to manage some or all of the Medicaid benefits. In addition, as a public Managed Care Organization under Vermont's Global Commitment to Health 1115 Demonstration waiver, OVHA has a responsibility to adhere to CMS MCO regulations, including those in C.F.R. § 438.236 regarding practice guidelines, which state that MCOs must have practice guidelines that (1) are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; (2) consider the needs of the MCO's enrollees; (3) are adopted in consultation with contracting health care professionals; and (4) are reviewed and updated periodically as appropriate.

The CURB approach is similar to the existing OVHA Drug Utilization Board and programs such as the Washington State Health Technology Assessment program which established an independent clinical committee to determine which medical treatments and devices are the safest and most effective for patients.

### Initiative

- i) No later than May 15, 2010, establish the OVHA Clinical Utilization Review Board
  - Composition: 10 members with medical expertise appointed by the Governor upon recommendation of the OVHA Director
  - CURB meetings will occur no less than ten times per year, and no less than monthly for the first six months in existence
- j) CURB responsibilities:
  - Identify and recommend to the Director opportunities to improve efficiencies in the OVHA medical programs, by:
    - Examining current high cost and high use services, as identified through medical claims data

- Reviewing current utilization controls to assess areas where improved utilization review might be indicated (e.g. use of elective, non-emergency out-of-state outpatient and hospital services)
  - Reviewing medical literature on current best practices and where current services do not have supportive evidence for their effectiveness
  - Conferring, as appropriate, regarding specific opportunities for exploration and subsequent recommendations, with the Commissioners of Health, Mental Health, and Disabilities, Aging and Independent Living, the Deputy Director of Alcohol, Drug Abuse and Prevention, the Blueprint Director, the Department of Corrections Medical Director, and the Department of Mental Health Clinical Practice and Advisory Council
  - Analyzing if it would be clinically and fiscally appropriate for OVHA to contract with the Centers of Excellence. The Centers of Excellence has a proven record of success in treating difficult health conditions or performing specialty procedures (e.g. oncology, transplants, bariatric surgery, pediatrics), and ensures that beneficiaries are seeing professionals and experts who are accredited and experienced in treating specific conditions with proven techniques
  - Considering the administrative implications for providers (positive or negative) of possible recommendations
  - Recommend to the Director the most appropriate utilization control mechanisms to implement the recommended evidence-based coverage guidelines (e.g., prior authorization; pre-payment, post-service claim review; frequency limits)
  - Prior to final recommendations to the Director, ensure that time is allocated during the CURB meeting for public comment and identify other ways to solicit input
- k) OVHA Responsibilities
- The OVHA Medical Director will provide OVHA leadership for the CURB
  - OVHA will provide data support to the CURB to assist in their reviews
  - The OVHA Program Integrity (PI) Unit will inform the CURB of practices that have already been identified through PI reviews to avoid duplication of effort and estimated savings
  - OVHA will provide a per diem to the CURB members
  - OVHA will provide meeting space and other necessary resources required to meet the objectives of the CURB
- l) OVHA Authority
- OVHA shall have the final authority to evaluate and implement recommendations of the CURB
  - OVHA will implement rules, if necessary, for the specific recommendations, as prescribed by state and federal guidelines

## **Outcome and Indicators**

---

The Challenges for Change Outcomes that will be addressed include:

- Adults lead healthy and productive lives
- Vermonters receive affordable and appropriate health care at the appropriate time, and health care costs are contained over time

Indicators of achieving these outcomes include:

- Number of recommendations implemented
- Reduction in both the over and under utilization of services (e.g., decreased overuse of elective, non-emergency out-of-state outpatient and hospital services)
- Member satisfaction, as measured by the annual Consumer Assessment of Health Plan Satisfaction) (CAHPS) survey
- Changes in costs of medical services for specific medical conditions

OVHA will conduct a comprehensive evaluation of the program's success at improving clinical and utilization outcomes using administrative (claims) data.

## **Savings**

---

OVHA anticipates that savings in the range of \$3 - \$5 million (gross) funds may be saved in FY11 through the CURB efforts. This is in addition to the following utilization management savings already proposed in the Governor's recommended budget for FY11:

- \$2 million (gross) via Prior Authorization for selected high tech radiology
- \$110,000 (gross) via reducing the urine drug test reimbursement rate
- \$135,000 (gross) via limiting Pt/OT/ST to a total of 30 visits per year
- \$450,000 (gross) by reducing urine drug testing to 8 per year
- \$310,530 (gross) by limiting ER visits to 12 per year if not resulting in inpatient admission, transfer or death
- \$1.17 million by adding 3 new Program Integrity Staff

## **Changes Needed in Statute and Regulation**

---

In order to give OVHA the flexibility to achieve these savings and improve clinical outcomes, OVHA needs the statutory authority to:

- Have the final authority to evaluate and implement recommendations of the CURB
- Develop rules if necessary for the specific recommendations, as prescribed by state and federal guidelines
- In all other case, OVHA will not be required to submit these changes to a legislative review process

## **Timeline for Planning and Implementation**

---

In order to achieve savings for FY11, the CURB must be established by May 15 and begin meeting no later than July 1.

## **Investments Needed**

---

- OVHA will need additional human resources to provide the on-going data analyses for the CURB activities. This can either be in the form of additional contractor (HP) staff or OVHA staff.
- OVHA will potentially need other resources to implement the CURB recommendations. The type of needed resources will depend on the CURB recommendations (e.g. specialized vendor for specific prior authorizations, utilization management software, claim check software, additional clinical staff).

- OVHA will need resources to pay the CURB member per diem and other associated expenses.
- The range of these investments is from \$200,000 to \$500,000.

### **Information Technology (IT) Needs**

---

None beyond those identified above.

### **Stakeholder Involvement**

---

OVHA has worked with healthcare providers regarding the utilization management proposals in the Governor's recommended budget, which are very similar to the work proposed for the CURB. OVHA will continue to engage the Vermont Medical Society, the Vermont Association of Hospitals and Health Systems, and other providers and healthcare system entities statewide as this new Board is convened. As previously noted in the CURB responsibilities section, the CURB will confer as appropriate with relevant medical professionals and leadership with state government when considering specific areas for utilization management and best practices. In addition, OVHA will present the redesign to the Medicaid Advisory Board at the next available meeting.

# Challenges for Change

Vermont Department of Mental Health  
Vermont Department of Health: Alcohol and  
Drug Abuse Programs

# Vermont Department of Mental Health

## Vermont Department of Health: Alcohol and Drug Abuse Programs

### Challenges for Change

#### Executive Summary

---

The Department of Mental Health (DMH) was created in 2007 to address the “mental health needs of all Vermonters”. This proposal was developed with that mission as its foundation. The goal of this effort is to continue to improve the mental health of citizens by increasing access to a continuum of services, decreasing redundant services and documentation, and actively working with the Blueprint for Health, OVHA within the overall health care reform framework. DMH and the Designated Agencies have worked collaboratively with Blueprint staff and consultants to work toward the creation of medical homes with mental health and substance abuse screenings and supports. Along these lines, the Blueprint concepts will be expanded by developing integrated mental health and substance abuse medical homes, which will provide physical health supports as an aspect of their service menu. DMH has formed a strong partnership with the ADAP office of the VT Department of Health to offer services that are co-occurring informed and coordinated.

In addition to OHVA and VDH the Department of Disabilities, Aging and Independent Living is a partner with DMH in providing funds for the ElderCare outpatient care program and a variety of supports for persons with serious mental health conditions. DAIL also provides significant support to the Designated Agency system through Vocational Rehabilitation programs for adults and teens, across a number of AHS funded programs.

The initiatives, outcomes, and savings reported here reflect a unified vision of health, mental health, and substance abuse programming. The changes proposed reflect that inpatient and outpatient services will be re-designed and be based on the needs and demographics of the consumers walking in the door, rather than programming for one or two specific populations or needs. There success will be based on a systemic ability to adopt more client centered practices, to determine effectiveness of services and to constantly adjust the level and type of service needed to get the best outcomes for the consumer.

#### Initiatives

---

The department proposes substantial changes in the adult mental health services area, and smaller changes in other areas of care. Adult services are now composed of acute care services in Adult Outpatient Programs (AOP) and ElderCare Program (ECP), as well as in Community Rehabilitation and Treatment (CRT), the long term program for adults with serious mental health conditions. The changes proposed will begin to address several challenges. First, the need to provide more flexible services for those longer term consumers who wish to transition towards more independence but who are fearful that they will not have services if they need them in the future. Second, by creating a continuum of service for adults more consumers would be able to benefit from packages that are supportive of their individual choices and needs at the time.

The need for a redesign of children’s health services—inclusive of physical health, mental health, and substance use prevention—is an area of improvements that are necessary, but not directly addressed in this document. Family and child program redesigns are encompassed in a

larger effort to address services across all areas of AHS via Integrated Family Services (IFS) and addressed in a separate proposal. DMH is a full partner in that proposal.

The next areas of care addressed in this document involve emergency services, health improvements, and better uses of current technology. The initiatives include:

- The integration of currently separate adult mental health programs into one continuum of care based on levels of functional need. This is a radical departure from the current diagnostically driven admission to one program or another. The expertise of clinicians would more easily be used across programs while changing the reimbursement to a case rate method based on service need as is currently used in CRT.
- Creation of a 1-800 statewide mental health services phone line for after hours emergency needs
- Backfill federal grant funds that are ending to continue to support improvements for co-occurring conditions (substance abuse and mental health conditions) across the system of care
- Monitoring Designated Agency (DA) quality for mental health and substance abuse services via national quality and accreditation bodies instead of by the state
- Changes in documentation and billing procedures, treatment planning and required sign-off by physicians will be expanded to include nurse practitioners.
- Annual improvement of employment of CRT consumers, with incentive based contracting in partnership with the creative workforce (VR) proposal. .
- Development of web-based data on mental health outcomes to better track improvements of clients and assess use of inpatient and crisis services.
- Training of DA providers and related private providers in core and expert services to improve outcomes for all Vermonters and decrease use of inpatient and other out of home care
- Reduce the number of days of hospitalization at VT State Hospital by 1260 days annually through changes in forensic observation and involuntary medication statutes and practices.
- In collaboration with Blueprint for Health efforts
  - Provide evidence based services to support physical activity and improve overall health of persons with serious mental illness.
  - Support DA collaboration with Federally Qualified Health Centers (FQHC) for 340-B pharmacy use—substantial savings for purchase of medications in the Medicaid program.
  - Ensure that best practices are utilized by health care professionals regarding the use of child psychotropic medications

(Further detail on the savings and necessary steps to gain them are in the appendix of this document.)

## **Outcome and Indicators**

---

DMH will be working collaboratively with OHVA, VDH, DCF, and other state departments and divisions to obtain and assess indicators and outcomes for the Challenges initiatives. Our outcomes and indicators will include the ability of the system of care to:

- Maintain access/allow for variation of service use by improved assessment and client directed goals/create tier oriented services across adult services
- Decrease response time callers for after hours emergency callers
- Decrease redundant quality reviews/decrease administrative burden for DA's to support a 1% increase in staff productivity
- Improve employment of CRT consumers, minimally 1.5% annually
- Achieve a goal of 50% of DA clients in 8 locations use of FQHC 340-B pharmacy
- Improved use of data from DA and AHS assessments to identify best practices and outcomes in variety of areas.
- Decrease attrition and improve skills of DA staff by increasing ongoing training and learning opportunities.
- Decrease use of local hospital emergency departments for emergency intervention
- Decrease medical and surgical and psychiatric inpatient care for person with Co-Occurring Conditions (substance abuse and mental health conditions)
- Closer adherence to best practices for health professionals—e.g. limit use of more than one antipsychotic medication and
- Complementary use of therapy in situations where psychotropic medications are prescribed

## **Savings**

---

DMH has estimated a savings of \$5.2-6 million dollars in savings in FY 2011. There still are estimates which must be completed in various areas.

## **Changes Needed in Statute and Regulation**

---

The Department of Mental Health (DMH) proposed two areas of legislation for the 2010 session which can be preferred methods of reducing unnecessary expense to state government. These two areas, involuntary medication and court ordered forensic observation were proposed for legislative action in the form of two bills:

- H. 616 An act relating to involuntary mental health treatment, and
- H. 631 An act related to court ordered forensic evaluation of criminal defendants

Both bills are focused on the Challenges for Change main concept, to alter areas of service that do not achieve outcomes useful to clients, and/or are poor use of resources by which a better investment of funds could improve the lives of those persons.

House Bill 616 was introduced by Representatives Koch of Barre Town, Lenes of Shelburne and O'Brien of Richmond in the 2010 session and supported by DMH as well as NAMI-VT, and many inpatient providers in the state. The bill is referred to the House Human Services Committee, but has not yet been engaged by the committee. The issue the bill was created to address is the extraordinary delay that the current legal process for application of treatment with the use of involuntary medication for those persons who are not responding to other, less invasive interventions. Currently the time required for the current process is an average between 60-70 days. For the past three years DMH has attempted to reduce this timeline, with limited success. As noted by consultants employed by the 2007 Legislature, the average time was 109 days. Efforts by DMH Legal and VSH physicians has reduced this time, however, there is little else that can be done to go any further. At this time the initial committal court hearing,

subsequent filing, and application for involuntary medication use hearing is approximately 70 days.

H. 616 proposes an alternative that utilizes a standard used by many states in recognition of the need to assure any proposed patient is lacking in the capacity to make decisions on their care, and that when this it is determined they do not, whether the use of medication against their consent may be given. The intent of the legislation is to focus on helping the patient to regain adequate capacity to participate in the treatment planning for their recovery. Once capacity has been restored the patient would again retain their right to guide treatment as they see fit. It is recognized by the DMH that this does not infer that medication alone will accomplish recovery, nor does it infer that the use of medication for all patients lacking capacity is the only choice for care. However, it is observed by DMH, VSH, and many psychiatric providers that the current process fails to address the needs of patients, primarily those with highly disabling psychotic disorders, to regain capacity in as timely manner as possible. It is recognized by this same group and others such as NAMI-VT, that there is a higher probability of trauma to the patient, and to fellow patients when involuntary treatment is delayed, sometimes resulting in serious physical and emotional harm. Most recently the peer community has expressed concern that persons with debilitating psychosis and who are violent should be able to move through the medication process as quickly as possible—while still maintaining all due process rights—in order to minimize possible harm to other patients.

In the past three years DMH observes that patients have often experienced delays in resolution of involuntary treatment applications for 90 days or more. Reducing this length of time would allow for a reduction in the use of extra staffing, a reduction in the number of days of hospitalization, and most importantly a reduction in the number of events when restraint and seclusion, and patient and staff injuries occur. DMH estimates that if the 20 persons—about the average number of involuntary treatment orders granted annually—were granted orders in 30 days or less from admission to use of medication VSH would reduce bed days by approximately 600 bed days annually. The cost of these bed days, at \$1,378 per day, would equal about \$826,800.

The second bill, H. 631 addresses a similar issue of the use of beds at VSH when other avenues of care could be more useful. DMH estimates it is the case that as many as a third of the forensic observation patients now orders to VSH for forensic observation, when their need for inpatient care is not necessary. House bill 631 is referred to the House Judiciary Committee this session, but no action has occurred this session. The bill proposes that an individual who does not meet criteria for acute inpatient hospitalization not be admitted to VSH, but instead returned to the court for other disposition. The data on the forensic population 2009, which involved about 100 admissions for observations--fairly close to a three year period of similar annual numbers, indicate that the 43 people found to be competent at VSH averaged 20 days to discharge or 860 bed days. Added to this are the 25 people found to be sane at VSH averaged 16 days to discharge or 400 bed days. Thus these two categories give us 1260 bed days used annually. We can not assert that all these persons are not meeting criteria for hospitalization, but our review would find it reasonable that about half these days are not likely to be needed, for at total of 660 bed days. The cost for care in the use of 660 bed days is approximately \$909,480 annually. It is noted that concern could be focused on the DOC risk of increased need were this legislation have the expected impact. However, of the 68 persons who were evaluated as sane and competent in

2009 only 8 were placed in DOC custody after the forensic evaluations were reviewed by the court.

DMH has been in consultation with Judge Davenport of the Court Administrator's office to discuss both of these proposals. The department is highly committed to working with the Administrator's office to make changes in the areas of involuntary medication court processes and alteration of the current inpatient forensic observation process.

The total for both legislative actions could reduce the use of approximately 1260 less bed days, and represents 7% of all bed days at VSH (based on a 3 year average of 18,579 annual bed days). The value of the savings here would be difficult to quantify exactly, however 1260 less bed days would reduce VSH by 3.45 beds annually, or approximately \$1,736,280. The reduction of these beds in the month of March 2010 would reduce the census to 41.5 per diem. At that level VSH would be able to engage in cost savings that could equal data projected for DMH from Pacific Health Policy Group regarding being able to run VSH at a 40 bed census. This data indicates it is reasonable that a reduction of these beds annually could reduce VSH cost by a net of \$850,000 (currently this would be in General Fund dollars). The savings in the proposals are established by fewer full time positions as well as a reduction in overtime costs; possible without reducing services for persons who need them. A note that the governor's budget for FY 2011, does have a reduction for overtime and costs that would likely limit savings here to a net of no more than \$200,000-\$300,000.

The total savings are subject to many forces that could reduce or enhance that value. The overall reduction in use of 3-4 beds at the hospital would be preferable to reductions in the community system which already is under stress. This combination could allow for an overall reduction in spending that would adhere to the Challenges for Change targets, perhaps encompassing the reduced spending for FY 2012 as well. DMH would strongly recommend consideration of these two actions, already in bill format and assigned to committee.

### **Timeline for Planning and Implementation**

---

The DMH and ADAP projects areas identified for savings can commence at the start of the Fiscal 2011 year.

### **Investments Needed**

---

At this time the total investment cost is yet to be determined. An RFP has been issued for the 1-800 line, but responses are not yet in to determine what kind of model might be employed. Investments in other areas remain in need of reasonable estimates. There are some IT related costs that are indicated below.

### **Information Technology (IT) Needs**

---

The use of the 1-800 line will likely require some IT consultation, but the hardware needs are not yet clear. The investment for web based data is a current IT project, and has been estimated to have a need of 1 FTE data administrator.

## **Stakeholder Involvement**

---

DMH has been engaging with both the DA system representatives in adult and children's mental health, and been meeting with the Adult and Child State Standing Committees, the VT State Hospital Steering Committee, and the Mental Health Transformation Council since November of 2009 to discuss the budget for 2011. These meetings have provided input from the peer community on a consistent basis, and DMH has received outlines of possible areas of attention from the DA's. DMH has also been engaged with other AHS departments—primarily DAIL, DCF, and VDH. As well as the DA's we have also consulted with substance abuse providers, homeless shelter leadership, and other community services agencies.

**APPENDIX A**  
**INDIVIDUAL PROJECT PLANS**

## **FQHC/DA Collaboration for Prescription Services and 340 –B Savings**

The establishment of the use of the FQHC system of care as a dispensing agent for the individuals who now uses DA MD/APRN services for psychopharmacological needs is a prime area for cost reduction. With a well designed collaboration the psychiatric needs of DA patients can be shared with the FQHC for expense both to the agencies and to OHVA for pharmacy costs.

Currently the DA system is challenged to gain adequate reimbursement that can cover the cost of prescriber expense. (All DA's currently have at least a psychiatric physician and many also now have APRN's to address pharmacological needs of patients.) The reimbursement to FQHC's for the same services are greater due to cost based reimbursement thus they can better absorb these costs. An even greater gain in terms of reduced state expense is the use of the FQHC pharmacy for the DA consumer, especially for the CRT population that has significant pharmacy cost. Savings for use of this pharmacy system are estimated here at a level of 6% overall savings for OHVA and an estimate of what the DA cost reduction could be for psychiatry should be at least 50% of that cost be shifted to the FQHC via collaborative agreement. There are complications to address in this system—record access, agreements that are in keeping with the federal and state requirements for DA's and FQHC's, but with a properly constructed system these can be managed to maintain the overall gain. The current estimate of savings, if 50% of DA patients were to use the 340-B option for pharmacy, would be at least \$350,000. The estimate is based on a conservative expectation of 6% savings to OHVA and the only on 50% patient use of FQHC in 8 of the 10 DA locations for which a FQHC is located within 20 miles. The development of an FQHC for the Bennington area, and the location of future clinics within the areas of greater populations would boost these saving considerably.

As well a further savings may be gained in sharing the prescriber cost between the FQHC and the local DA. Average psychiatric costs nationwide are currently in excess of \$150,000 annually ([http://swz.salary.com/salarywizard/layouthtmls/swzl\\_compresult\\_national\\_hc07000027.html](http://swz.salary.com/salarywizard/layouthtmls/swzl_compresult_national_hc07000027.html)). For APRN the average is \$80,000 nationally, based on information from payscale.com. ([http://www.payscale.com/research/US/Certification=Advanced\\_Practice\\_Registered\\_Nurse-Board\\_Certified\\_\(APRN-BC\)/Salary](http://www.payscale.com/research/US/Certification=Advanced_Practice_Registered_Nurse-Board_Certified_(APRN-BC)/Salary)). The DA reimbursement is possible to afford for the APRN, but this is the upper limit. For a DA to cover the cost of a psychiatrist is not possible with current reimbursement. For both areas of practice reimbursement via the FQHC model is far superior for both the rate of reimbursement and the increase federal match provided for the FQHC provider. Even a 10% savings for the cost of these professionals would add approximately \$200,000 in cost reductions to the DA. The final savings, taking into account that OHVA would still be providing payment for the FQHC services should still allow for substantial savings. Thus the final savings for implementation of this plan would be estimated between \$100-200,000 annually.

## **Adult Services Consolidation**

The community mental health designated agencies (DA) have operated separate Adult Outpatient (AOP) and Community Rehabilitation and Treatment (CRT) Programs for decades. AOP has traditionally been funded through a fee-for-service reimbursement structure, providing primarily psychotherapy and medication management services to individuals with a multitude of mental health conditions. These individuals tended to have situational issues or stressors impacting their current mental health, but this program was not intended to maintain chronic or enduring conditions; nor was it structured to provide skill building or case management services to this population. Additionally, AOP services operate as clinic or office-based therapeutic services to the population served with little outreach presence or larger social mission to their community.

The CRT Program on the other hand serves a mandated population who has serious and persistent mental illness and provides a variety of support and psychosocial rehabilitation services. These services are frequently community-based and enhance the social networking needs necessary to connect individuals with their communities. The services focus on essential functional skill development and active rehabilitation for mental health conditions that inhibit daily activities, social connections, and employment opportunities.

Under the Global Commitment Medicaid Waiver, the funding silos existing between these two programs is no longer required nor do the silos support or encourage a transition between these programs for individuals who are recovering from their mental illness. Individuals in the CRT Program, who may require some support services, but no longer require an extensive array of mental health services, have few options for intermittent support in AOP. Investing existing adult services resources in a more broad-based manner, allowing a more fluid benefit package for persons served across the adult services continuum, supports a more client-centered service approach.

A designated agency adult services program would be designed to bring persons served into a program that will meet their individual treatment needs without service parameters subject to a specific funding stream. Drawing upon the existing CRT Program capitated payment funding structure, adults would be served by local DA's who will receive a monthly reimbursement for these services. Resources in the adult services program would be targeted to individuals who have more intensive and ongoing skill building, case management, and psychosocial services and support needs. The allocated resources would be tiered to reflect the intensity of services needs for persons served in the program. Resources in this program would be dedicated to the more community-based social service mission and limits placed on the provision of clinic-based therapy via this funding. Further criteria for transition and referral out of the adult service program would be established and limits placed on and diminishing funding reimbursement for the population at low levels of need and continued in service beyond a threshold established for service delivery. Incentives within the capitated funding structure would be created to encourage and welcome new enrollment of more complex and ongoing clients served. This approach would both encourage movement through the service continuum by diminishing reimbursements for long-term service attends and establish incentives to outreach and enroll new persons served.

By contract, the Agency of Human Services through DMH would begin to initiate these changes in the upcoming fiscal year. Identification of priority populations, who would benefit from a broader mental health services program, would be identified via agreement with service

providers. Traditional referral partners would continue and include the forming Local Adult Interagency Teams and State Adult Interagency Team as priority sources of referral. The development of a payment methodology to support this change concept would also need to be established with existing funding resources.

While this start-up activity will be time intensive over the next few months and generate concerns that this redesign in expectations of the existing service programs will weaken the DA's capacity to provide traditional psychotherapy services, these program changes are directly in line with addressing more proactively the needs of individuals at higher risk in their communities for health, mental health, and social service expenditures. These savings would be realized over time through more timely and successful mental health intervention and service coordination efforts for individuals who would otherwise. The redesign is also consistent with and responsive to what has been identified by the DA's as the population most at risk in the community by reductions proposed in the existing AOP services. This redesign proposes to continue service to this population and decrease the use of existing resources for those individuals who could be served by private mental health practitioners who are enrolled Medicaid providers.

This plan would reduce the total allocation to AOP, CRT, ECP, and CRT Inpatient, \$44,657,779 by \$3.0 million dollars. The remaining funds would be redistributed with an emphasis on Urgent and Emergent Care Services and Adult Treatment and Support Services. Urgent and Emergent Care Services would combine existing Emergency Service Program funding to maintain emergency response and capacity for urgent, brief stabilization-focused care. DMH funding would target this service capacity and limit its funding to no more than six follow-up therapy services for this population. This limit is necessary to immediately influence and decrease DA utilization of its funding from an unlimited clinic-based outpatient therapy service treatment model to one of brief treatment and referral for the population intended to be served. This change in program focus will also need to be identified in the Master Grant Agreement for FY 11.

The Community Mental Health Adult Support and Treatment Services (CAST) program would similarly combine existing CRT Program Adult Outpatient and ElderCare Programs. This program would maintain parameters for the CRT Program by serving a new Intensive Needs program service recipient. The CAST would also serve a new Moderate Needs program service recipient. DMH funding would target case management services and psychosocial rehabilitation skill building supports for a population who previously either did not respond effectively or need traditional clinic-based outpatient therapy service parameters or who were ineligible for these service interventions given Medicaid State Plan limitations targeting the most disabled. The moderate needs group would also be identified through referrals from the Urgent and Emergent Care Program who do not refer to other community mental health practitioners. The moderate needs group would also be subject to service limits, but program duration could be from 18 – 24 months to promote stability, avert development of more chronic mental health care needs, and establish better connectivity with other community organizations and social services networks. Again, without the identification of time-limited mental health supports services and focus on mental health recovery and skill development, there is little incentive for movement through and out of program services. An investment of DMH dollars to serve this target group will divert individuals from high cost or institutional care services over time. This change will require additional financial analysis over the next couple of months to establish a case rate payment

methodology and structure for Intensive and Moderate needs clients, comparable to the CRT Program as it currently exists, for each DA to serve this target population.

### **Emergency Services redesign/1-800 statewide services for after hours calls**

Currently, each Designated Agency (DA's) has a Emergency Services program, which function 24 hours a day. These clinicians provide crisis intervention, assessment and triage both telephonically and in person. One DA, Washington County Mental Health, answers calls and provides after hours emergency services for Clara Martin Center and for Health Care and Rehabilitative Services. This arrangement resulted in increased positive remarks by consumers on services at all DA's, and resulted in savings for CMC and HCRS.

As part of the Challenges for Change for the mental health system redesign DMH supports consolidating the after hours DA emergency services delivery to either one that is a centralized or regionalized point of service. In order to promote this idea and move it forward, an RFP (or limited bid) has been issued to the DA system to manage a 1-800 crisis call center, with awake Master's level staff to answer crisis calls after hours.

Because DA's largely function independently from one another, to make a change to the pre-existing Emergency Services program would necessitate a change to the DA master grant agreement to reflect that after hour calls would be either centralized or regionalized and managed by either the DA system or an outside vendor.

It is anticipated that the deliverable could be finalized and made operational by July 1, 2010.

Savings on this plan are difficult to estimate beyond a range of \$100,000 to \$200,000.

Quality assurance would occur as response time by phone, and follow up in person by local agencies would be recorded.

### **Health Integration - Physical health and wellness for severely mentally ill population (In Shape Program)**

Many people who live with severe mental illness are beset with multiple medical problems, the reasons for which are multi-factoral. One way to mitigate the multiple medical problems is through the application of and participation in an exercise and lifestyle change program.

Currently, there is one such program in NH which has had great success in moving health indicators for people living with severe mental illness in positive directions. Dartmouth Psychiatric Research Center has partnered with the mental health agency to track and measure outcomes. Since its inception in 2003 the In Shape program has demonstrated these results:

- 20% of participants have ↓ their weight by > 10 lbs
- 20% of participants have ↓ their waist circumference by > 10 cm
- 33% of participants have had a ↓ in systolic Bp of > 10Hg
- 25% of participants with depression showed a more than 50% ↓ in symptoms

A \$25k start up fee is required in order to have the NH mental health agency provide training and technical assistance for its In Shape program. Designated Agencies could certainly design and implement their own health and wellness program which could produce similar outcomes for

participants. There are options available to encourage and motivate people around engaging in healthy lifestyles (Wii Fit is an example of something more cost effective than a \$25k fee). The design and implementation of such a program would dovetail with the Blueprint for Health in that people living with severe mental illness participating in a Designated Agency sponsored health and wellness program would be managing their health, improving their quality of life, increasing their confidence while potentially decreasing pharmacy and inpatient hospital costs.

If Designated Agencies chose to develop their own programs independent of the In Shape program, they could potentially have an in-house program operational by July, 2010, with an identified staff and a cohort of participants.

### **Increased use of data indicators of client wellbeing**

**Level of Care Utilization System (LOCUS)** - The Vermont Adult Mental Health Care Management Steering Committee has recommended adoption of the LOCUS tool to aid the Department of Mental Health (DMH) management in guiding treatment decisions for locations such as group homes, crisis beds, and inpatient beds. The LOCUS tool will facilitate the collection of data regarding level of care utilization and provide scoring and reporting based on that data, resulting in more accurate placements and less work for DMH and its provider staffs. Use of the data will maximize efficiency in resource utilization and reduce staffing needs at the provider level, aid in the proper evaluation of clients and placements, and support the decision making processes throughout DMH and partner agencies.

This project has been presented to the AHS IT Strategies group and is awaiting approval. DMH cost to implement is \$25,300 with a \$3,289 annual support fee. (This investment is in the 2010 budget of DMH.) Additional costs are operational in nature (estimated 1 FTE for training, monitoring, AHS IT for acquisition, project management, contracting, etc). This cost would be shared among other IT initiatives, such as ASEBA. As a part of their contracts, DMH currently asks that facilities report this information but have not provided a mechanism for the reporting. Considerations have been made to ensure that duplicate data entry by facilities already transmitting data to DMH is kept to a minimum.

Return on investment will amount to savings generated by ensuring proper placements and measurable outcomes at discharge.

**Achenbach System of Empirically Based Assessment (ASEBA)** - The Child, Adolescent and Family Unit is continuing to move forward with the use of the ASEBA. Currently the ASEBA is required for the Youth in Transition Grant, the Trauma Grant, the Behavior Interventionist Minimum Standards, and all waiver and residential referrals. We are also working on pilot project in Franklin/Grand Isle to try and streamline the administration and sharing of ASEBA data between NCSS, primary care, DCF and schools. Additionally we are working with the DA's and SSA's to begin implementation of the ASEBA across all their programs and hope to have that up and running by the end of the fiscal year. This information will help clinicians and treatment teams assess current functioning in the 8 syndrome areas and gauge response to treatment. Additionally this will allow managers to look at programs as a whole and make programmatic changes as needed.

The Youth in Transition (YIT) grant has built in dollars to support their ASEBA requirement. The other required programs and the implementation to all programs will cost approximately \$22,800 per year. However there may be areas that we can save on costs because the school, primary care or the DCF office had recently completed an ASEBA. That is the goal of the Franklin/Grand Isle project to determine how to best share that information in order to reduce redundancy. The Franklin/Grand Isle project is being supported by ARRA funds.

**DMH/Futures Bed Board** - The Futures Project is developing an electronic bed board which can track the use of residential, crisis, long term care, and psychiatric inpatient bed use across the state. With LOCUS in use as well, this would better measure the outcome of the use of these resources and help to create an environment of using the best level of care for patient need. An RFP for this project will be issued shortly.

### **Quality Management More efficient/cost-effective Departmental oversight mechanisms**

Prior to staff reductions, DMH maintained a schedule of site visit activities annually or bi-annually to assess the quality of DA Programs and clinical documentation. All site visit activity was directed toward the monitoring of standards outlined in Administrative Rules and rolled up to an every four year Agency Designation process. The activities were time intensive for both the DA's and the DMH central office for pre-planning and data collection activities, on-site meetings with staff and stakeholders, and post-site visit report creation/dissemination.

These oversight mechanisms were modeled after national quality accreditation standards and tailored to meet agency designation requirements. DA's have long felt this to be a redundant oversight process when a DA was accredited by a national organization. Recently, some DA's have discontinued accreditation as both a cost savings for their agencies and given ongoing DMH and DAIL oversight processes, regardless of accreditation status.

A proposed change for quality management oversight would be the introduction of incentive funding for the DA's to seek and then maintain national accreditation by an external review organization. Requiring the DA's to become accredited would then reduce the need for both DMH and DAIL to conduct on-site reviews allowing both the DA's and the state agencies to experience cost reduction and savings over time.

There is currently \$500,000 available for new initiative incentives. This funding could be used as incentive funds to jump start DA's who have not had national accreditation. DMH and DAIL could also pull back out funds from current DA allocations to support this process and make a lump some payment to the DA upon receiving accreditation. The DA's would transfer existing staff time from preparing for DMH site visits to preparing for national accreditation survey. DA's could also benefit from accreditation by securing better reimbursement rates from private insurance contracts. DMH could scale back activities to only monitor Vermont specific Administrative Rules requirements, much of which could be done through desk audit activity rather than on-site review. DMH could focus on specific issues that arise, rather than generic evaluation activities. These activities would also follow and rely heavily upon the existing accreditation cycles and reporting requirements, which would then inform the Agency Designation process.

It is anticipated that the deliverable could be introduced and phased in through master grant agreement beginning July 1, 2010. There would be immediate implementation for DA's that are nationally accredited currently. Crosswalk of Joint Commission and CARF standards is nearly complete and "deeming" of provider standards for accredited DA's is already beginning for the present Agency Designation process. This should be an immediate efficiency with regard to staff productivity at the DA level and travel cost savings for DMH staff.

### **Chittenden Project: VDH/ADAP Maple Leaf Farm and the Howard Center**

The following parts of the Chittenden Project could be expected to produce clear outcomes with a high level of confidence. Should they produce or exceed the expected results, they could easily be folded into a full Chittenden Project in the future.

1. Maple Leaf Farm and the Howard Center are implementing a joint Intensive Outpatient Program (IOP) in anticipation of the Project. A staff member who runs the IOP meets with Maple Leaf Farm patients before they are discharged to discuss and arrange for IOP participation. Increased Medicaid allocation will allow the Howard Center/Maple Leaf Farm IOP to serve these additional patients. This increases access to ongoing treatment services.
2. Additional medical and psychiatric services at MLF will allow response to more complex cases. This reduces psychiatric unit stays at hospitals.
3. Outcome measures:
  - a. Increase access to addictions treatment.
  - b. Decrease use of ED for emergency intervention
  - c. Decrease medical/surgical and psychiatric inpatient care for co-occurring disorders (number of bed days)
  - d. Decrease DOC costs (number of bed days)
4. As of 3/26/10 the expected cost for this project is approximately \$400,000. Based on current estimates of savings it is reasonable to estimate a savings of approximately \$100,000 due to decreased inpatient (both medical/surgery and psychiatric related). ASAP will be working with OVHA, CSME and Blueprint to gain a more precise determination on measures for all costs savings related to this project—other than inpatient there are estimates that less service use over time, less benefit need overtime, and other areas of savings may be possible. ADAP will start by identifying 10 patients and determining Medicaid costs pre-treatment, during and post-treatment. This will establish baseline data to develop a better model for savings. ADAP will also work with CSME staff to determine how to include this ADAP data component as part of ongoing AHS work (Medicaid only).

### **Best practices are utilized by health care professionals regarding the use of child psychotropic medications**

Through work with a DMH Child Fellow Grant (via reallocation of funds) to the UVM Department of Child Psychiatry's, VT Center for Children, Youth and Families (VCCYF) DMH will begin an academic detailing effort concerning use of psychotropic medications for children by primary care providers. The DMH led Child Medication Review Team, with ongoing support

with BISHCA and OVHA and DCF for data and staff time will continue this effort begun in 2008. Data from BISHCA regarding private insurance prescription trends will be used as will data from OHVA on similar areas. DMH Research and Statistics staff will continue to analyze data and provide reports. The outcomes for this project will be:

- Closer adherence to best practices for health professionals [i.e. 1) limit use of more than one antipsychotic medication and
- Complementary use of therapy in situations where psychotropic medications are prescribed

Projected cost savings by this practice support will need further analysis of current practice patterns and increased adherence to evidence-based prescribing patterns. At this point in time it is likely any cost savings would be indicated through less expenditure by OVHA, thus specific tracking measures will have to be developed.

*(Note - Included here are the 10 strategic initiatives identified by the new SAMHSA administration. Numbers 1, 5, 7, 8, and 9 all relate to the targets of the DMH/ADAP/Blueprint efforts in the Challenges for Change document. DMH has other efforts via SAMHSA grants in the areas of numbers 3, 4, and 10 as well. This alignment increases the opportunity for DMH, VDH/ADAP or OHVA to win future grants to further help adjustments to the new Challenges environment.)*

## **SAMHSA's 10 Strategic Initiatives**

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. Over the years SAMHSA has demonstrated that; prevention works, treatment is effective, and people recover from mental and substance use disorders. Behavioral health services improve health status and reduce health care and other costs to society. Continued improvement in the delivery and financing of prevention, treatment and recovery support services provides a cost effective opportunity to advance and protect the Nation's health. To continue to improve the delivery and financing of prevention, treatment and recovery support services SAMHSA has identified 10 Strategic Initiatives to focus the Agency's work on people and emerging opportunities. The 10 Initiatives are described below with the Agency lead identified.

### **1. Prevention of Substance Abuse and Mental Illness (Fran Harding, Director, CSAP)**

Create prevention prepared communities and to focus on prevention of mental illness and substance abuse, focusing first on children and youth, and eventually serving individuals, families, peers, schools, businesses and communities across the lifespan.

*(This is highly correlated to the work of Blueprint and other AHS health improvement efforts.)*

### **2. Violence and Trauma (Kana Enomoto, Principal Senior Advisor to the Administrator)**

Reduce the behavioral health impacts of violence and trauma and integrate trauma-informed services in prevention and treatment programs in States and communities, and throughout the health service delivery system to address root causes of pervasive, harmful, and costly public health problems. Divert youth and adults with substance use, mental disorders from criminal and juvenile justice systems into trauma-informed treatment and recovery.

*DMH currently has a three year SAMHSA grant for addressing trauma care for children. We will be continuing to work to expand this to all populations.*

### **3. Military Families – Active, Guard and Veteran (Kathryn Power, Director, CMHS)**

Support of our service men and women and their families and communities by leading efforts to ensure needed behavioral health services are accessible and outcomes are successful.

*(DMH and UVM are collaborators on a SAMHSA grant, MHISSION -VT to address needs of veterans related to the criminal justice system, and the children's trauma grant includes working with military families.)*

### **4. Housing and Homelessness (Kathryn Power, Director, CMHS)**

Provide housing and reduce the barriers that homeless persons with mental and substance use disorders and their families experience when accessing programs that sustain recovery.

*(DMH is working with Housing First to improve outcomes for persons with mental health conditions and housing needs.)*

### **5. Jobs and Economy (Larke Huang, Senior Advisor to the Administrator)**

Use funding streams to boost employment opportunities in communities for people in need of jobs including people with mental and substance use disorders.  
*(The Challenges proposals in this document address this area.)*

**6. Health Insurance Reform Implementation (Eric Broderick, Deputy Administrator)**

Achieve equality with all other health conditions for the prevention and treatment of mental and substance use disorders.

*(This is highly correlative to the Blueprint for Health efforts by VDH and DMH)*

**7. Health Information Technology for Behavioral Health Providers (Wesley Clark, Director, CSAT)**

Ensure the behavioral health provider network, including prevention specialists and consumer providers, fully participate with the general health care delivery system in the adoption of health information technology.

*(DMH is working with OHVA's lead on developing this area for mental health care)*

**8. Behavioral Health Workforce – In Primary and Specialty Care Settings (Wesley Clark, Director, CSAT)**

Provide a coordinated approach to address workforce development issues affecting the behavioral health service delivery community.

*(This is directly related to the Blueprint and the efforts by DMH to establish a DA training on health/mental health related concerns of clients.)*

**9. Data and Outcomes – Getting Results (Pete Delaney, Director, OAS)**

Realize an integrated data strategy that informs policy and measures program impact leading to improved outcomes for people in need of services.

*(Through Challenges for Change DMH is increasing our attention to develop of improved data gathering and meaningful outcome measures)*

**10. Public Awareness and Support (Mark Weber, Director, Office of Communications)**

Change how mental health and substance abuse services are perceived so that people seek help for these conditions with the same urgency as any other health condition.

*(DMH currently has a SAMHSA grant to increase awareness of teen suicide and prevention strategies)*

# Challenges for Change

Department of Disabilities, Aging  
and Independent Living (DAIL)

# Department of Disabilities, Aging and Independent Living Challenges for Change

## Executive Summary

---

**The Department of Disabilities, Aging and Independent Living (DAIL) is utilizing the opportunity presented by Challenges for Change to improve and modify our existing client centered systems of care.**

DAIL intends to aggressively assist Vermonters to remain independent using home and community based services and as a result reduce nursing home utilization. In some counties in Vermont, nearly 60% of all persons needing nursing home level of care are served at home or in alternative community based settings. In other counties, the utilization of home and community based services hovers around 40%. Greater utilization of home and community based services is achievable, with an accompanying reduction in nursing home utilization.

Vermonters who need long term care and choose home based services can benefit from more flexibility in how the dollar allocation in their plans of care are utilized. This strategy is intended to allow more participants to remain independent. For example, Choices for Care has a limited set of service options that are paid for on a fee-for-service basis, unless the consumer chooses the Flexible Choices option, where, with the help of a counselor, the consumer manages his/her budget. Only a small group of consumers have selected this option. DAIL is exploring different payment mechanisms that can provide more flexibility to consumers.

Providers can also benefit from this flexibility since moving away from a fee-for-service system would reduce paperwork requirements and time for both providers and State staff.

DAIL is also exploring how to utilize the Developmental Services individualized service plans, which the Designated Agencies (DAs) and Specialized Services Agencies (SSAs) develop with clients, as **performance-based contracts** supporting better outcomes for consumers.

DAIL has also proposed legislative changes to **Medicaid estate recovery** law to increase revenues for the program to ensure persons most in need can continue to receive services.

Another concept involves redesigning the delivery and financing system to have home and community based providers in the long term care system receive **bundled rates** based on consumers' needs and preferences. The provider agencies, instead of being specialty providers, would accept the responsibility to either directly provide or arrange for all the services a participant needs. In return the provider would be paid a bundled rate based on a plan of care and perhaps a tiered system of rates. We believe this would create opportunities for savings; but it is a large and complicated change that will require more discussion and design time.

## Initiatives

1. Create incentives for home and community based providers to serve additional persons in community based settings.
2. Expand the list of available providers of home and community based services where necessary to assist in the aggressive effort to decrease nursing home utilization.
3. Expand the service menu and flexibility for home-based consumers to allow them to remain independent, even with constrained funding.
4. Develop different funding mechanisms for providers to reduce administrative burdens, while focusing more on outcomes for consumers.
5. Expand opportunities for elders and adults with physical disabilities to benefit from a 24/7 service option similar to the concept of developmental homes.
6. Encourage small nursing homes to convert to Enhanced Residential Care Homes, thus reducing the regulatory requirements for those homes while reducing expenditures.
7. Develop a process for “presumptive eligibility” to ensure consumers do not have to wait for long periods while eligibility is being determined, sometimes putting their independence at risk.
8. Set up an interdepartmental team to ensure that DAIL clients with mental illness are served in an integrated fashion and avoid unnecessary or prolonged stays at Vermont State Hospital.
9. Convert Vermont’s last six-bed Intermediate Care Facility for the Mentally Retarded (ICF/MR) to an Enhanced Residential Care Home, reducing regulatory requirements while reducing expenditures.
10. Strengthen estate recovery and maximize private contributions to Long Term Care Medicaid.

## Outcome/Indicators

<b>Outcome from Statute</b>	<b>Indicators (data source)</b>
Elders, people with disabilities and individual with mental health conditions live with dignity and independence in settings they prefer.	<ul style="list-style-type: none"> <li>• Reduction in paid claims to nursing homes (EDS/HP claims)</li> <li>• Increase in the number of persons enrolled in Choices for Care in home and community based settings. (DAIL’s SAMS database)</li> </ul>
	<ul style="list-style-type: none"> <li>• Percentage of respondents who report that they had a voice in the decision about where they live</li> <li>• Percentage of respondents who report that they are living in the setting they prefer.</li> <li>• Percentage of respondents who report that they are happy with their case manager</li> <li>• Percentage of respondents who report that they are happy with their service agency</li> </ul> <p>Note: consumer surveys are carried out by an independent contractor.</p>

## **Estimated Savings and Return on Investment**

---

We estimate that aggressive efforts to reduce nursing home utilization can result in up to \$5 million in net savings. This will mean that 167 additional beds will remain vacant on an annualized basis. This is after re-investing the funds necessary to serve additional persons at home or in alternative settings.

We estimate \$7.5 million in savings by utilizing individual service plans in developmental services as performance based contracts with better outcomes for consumers.

## **Changes Needed in Statute and Regulation**

---

For estate recovery and liens, DAIL will require legislative changes in Title 33.

We also need the language we proposed that would protect us and the DAs and SSAs from the continuing benefits issue.

## **Timeline for Implementation**

---

DAIL will begin the effort to further reduce nursing home utilization immediately, and this effort will ramp up once the incentives are designed and implemented.

Research on alternative financing mechanisms will begin immediately.

Work groups will be identified and assigned the weeks of March 29 and April 5.

## **Investments Needed**

---

DAIL will need some up front expenditures, approximately \$500,000 to serve additional persons at risk of nursing home placement until savings begin to materialize.

If a decision is made to move forward with financing changes such as tiered rates or bundled rates, DAIL will require a contractor to assist in the development of those mechanisms, in the range of \$50,000 to \$70,000.

## **Information Technology (IT) Needs**

---

DAIL will rely on the AHS enterprise service oriented architecture to meet IT needs for these initiatives.

## **Stakeholder Involvement**

---

DAIL leadership met twice the week of March 22 with key leadership from the provider community to discuss major concepts. DAIL leadership met with consumers and advocates twice on March 26, and in a meeting on March 29.

Consumers, providers and advocates will be integral part of all work groups as we move forward.

# Challenges for Change

## Creative Workforce Solutions

# Creative Workforce Solutions

## Challenges for Change

### Executive Summary

---

#### **Employment is the road to self-sufficiency**

Employment is the only practical mechanism to reduce dependency on services and benefits for Agency of Human Services (AHS) consumers. Recent and prospective reductions in AHS services increase the need for return to work services. Without effective employment services, reductions in AHS services may simply result in consumers returning to the system through another door. Yet, despite the critical importance of work in the lives of the people we serve, AHS employment programs are dispersed across four separate departments and at least seven divisions.

#### **Creative Workforce Solutions (CWS)**

The Challenges Workgroup has developed a consolidated and coordinated approach to employment services under a single entity called Creative Workforce Solutions (CWS). CWS will provide equal access to meaningful work in the competitive job market for all AHS program participants. It will also offer employers a single point of contact for coordinated job development and placement services across AHS programs.

#### **Operational Design**

All AHS employment services will be coordinated through CWS. CWS will establish common standards and tools for marketing and account management. Employer contacts statewide will be managed through a common account management system using Microsoft SharePoint.<sup>2</sup> At the local level CWS Business Account Managers will coordinate employer outreach through local employment teams built on the existing employment coalitions.

The service infrastructure behind CWS will vary based on consumer need, program requirements and program infrastructure. Some AHS programs already have well established employment services and these programs will coordinate employer outreach through CWS. Other programs that have almost no or limited community-based employment services will contract for employment services directly from CWS, based on the level of demand in their program.

#### **Outcome/Indicators**

---

AHS employment services are provided across four departments and seven divisions. While the broad outcomes are similar, meaningful indicators of progress will vary across populations and programs. Given the barriers to sustained employment among these populations, these goals are very ambitious.

---

<sup>2</sup> Microsoft SharePoint is a business collaboration platform that will offer a feature-rich integrated environment for CWS business account managers and job developers both within AHS and in our partner community agencies to collaborate; share job leads; employment market knowledge and ideas; connect with their colleagues, and easily find information and experts. Features that will be particularly useful for CWS include shared employer contact data, calendars and tasks, contact notes and email storage and management, document collaboration and versioning, resource libraries of employer marketing materials, and SharePoint's extensive tools for site administration, security and customization.

Outcome	Indicators
More AHS customers will be employed	<ul style="list-style-type: none"> <li>▪ CWS employment rates overall as measured through Vermont Department of Labor (VDOL) Unemployment Insurance (UI) quarterly earnings data.</li> <li>▪ <u>Department of Mental Health (DMH) Community Rehabilitation and Treatment (CRT) Program</u>: Employment rate of CRT consumers as a percentage of total served based on VDOL UI data.</li> <li>▪ <u>Department of Disabilities, Aging and Independent Living Services Developmental Disability Services (DDAS) Program</u>: Employment rate of DDAS consumers as a percentage of total served based on annual program reports.</li> <li>▪ <u>Department for Children and Families (DCF) Reach Up Program (RU)</u>: Work participation rates of RU consumers.</li> <li>▪ <u>Department of Corrections (DOC)</u>: Percentage of DOC consumers employed post release.</li> <li>▪ <u>Division of Vocational Rehabilitation (DVR) and Division for the Blind and Visually Impaired (DBVI)</u>: Number of individuals closed as successfully employed.</li> </ul>
Wages will increase	<ul style="list-style-type: none"> <li>▪ CWS consumer earnings across programs as measured quarterly through VDOL UI data</li> </ul>
Employment retention will increase	<ul style="list-style-type: none"> <li>▪ CWS consumer employment retention across programs as measured through VDOL UI data</li> </ul>
Benefits utilization and recidivism will decrease	<ul style="list-style-type: none"> <li>▪ RU consumer grants closed or reduced because of employment.</li> <li>▪ Cash benefit reductions—ReachUp, Supplemental Security Income (SSI), and General Assistance (GA)—resulting from employment for DVR, DBVI, Refugee Resettlement, and DOC populations served by CWS.</li> <li>▪ Reduced recidivism (re-conviction) for DOC and RU consumers</li> </ul>
Cost per outcome will decrease	<ul style="list-style-type: none"> <li>▪ Cost for initial placement and support.</li> <li>▪ Cost for long and short term post placement support.</li> </ul>
Customer satisfaction will increase for employers, consumers and stakeholders	<ul style="list-style-type: none"> <li>▪ <u>Employers</u>: Feedback through CWS coalitions and formal survey data.</li> <li>▪ <u>Consumers</u>: Survey data as measured through the various departments/divisions.</li> <li>▪ <u>Stakeholders</u>: CWS partner meetings.</li> </ul>

## Estimated Savings and Return on Investment

### Return on Investment

Effective employment services will reduce recidivism and benefits utilization. Employment will reduce dependency on services and benefits for AHS consumers. With reductions in other AHS services, effective employment services will be needed more than ever to prevent adults and families returning to the benefits rolls or service systems.

### Supporting Savings Across AHS Programs

- By consolidating Reach Up grants management through Creative Workforce Solutions we will both meet the 3% DCF.

- The employment initiative will support savings in the General Assistance (GA) program by moving chronic GA recipients to Social Security disability benefits and moving GA recipients off the rolls to work or elsewhere.
- The employment initiative will support and sustain the DOC Challenge savings. As more offenders are being managed in the community, finding and maintaining work becomes an essential service to sustain successful reintegration and reduce recidivism of offenders overall.

### **Performance Based Contracting and Revenue Generation**

- Over the next two fiscal years, \$2 million in VR funding for JOBS, CRT and DDS supported employment will transition to a structured pay for performance model.
- The last year of DVR's Medicaid Infrastructure Grant funding as well as possible federal VR reallocation and DVR ARRA funds will be dedicated to the implementation of this initiative.
- By increasing employment outcomes for Social Security disability program beneficiaries, CWS will generate additional federal revenue for the CRT, DDAS and VR employment programs.

### **Changes Needed in Statute and Regulation**

---

At this time, we have not identified any legislative or statute changes necessary to implement Creative Workforce Solutions as designed.

### **Timeline for Implementation**

---

The initial launch of employment as an AHS priority and the coordination of employment services through Creative Workforce Solutions is scheduled for a cross-agency Employment Institute on June 29<sup>th</sup> at the Statehouse. Work will continue within the 12 AHS districts to bring the CWS teams together under consistent operating principles. CWS will continue to work on the establishment and measurement of population-specific outcomes and indicators. CWS will host a follow-up statewide training event in the fall.

### **Investments Needed**

---

We request that AHS make available \$200,000 in General Fund dollars on a one time basis to the Division of Vocational Rehabilitation to draw down available federal vocational rehabilitation funds through re-allotment. \$200,000 would potentially draw down an additional \$800,000 in federal funds that could be used to seed this effort. The availability of re-allotment funds are dependent on other states not being able to draw down their full allotments and are therefore not guaranteed.

Other than this one time investment, Creative Workforce Solutions will be implemented primarily through reallocation of existing resources. The emphasis will be on using resources currently assigned to employment services in a more coordinated and effective manner.

### **Information Technology (IT) Needs**

---

We are in the process of developing an employer accounts management database using Microsoft SharePoint. This will be a key tool. We are in discussions with S-3 Technologies (a

preferred vendor) about assisting us with business process definition, workflow design and a simple database to begin early tracking of employment outcomes through CWS. S-3 is finishing up work with us to define the business processes for an integrated VR case management system that will allow partner participation and could be a platform for Creative Workforce Solutions across the agency.

We will be looking to the AHS Central Source for Measurement and Evaluation data (CSME) warehouse to track a number of key outcome indicators. These will include:

- Reductions in benefits utilization as a result of employment
- Increases in work participation rates for Reach Up participants
- Recidivism and re-offense rates for offenders

Several departments and divisions involved in CWS currently have access to Department of Labor Unemployment Insurance earnings data to track employment outcomes.

### **Stakeholder Involvement**

---

Impacted departments and divisions are all involved in the subgroups working on Reach Up, DOC, CRT, DDS populations and youth. Designated Agency staff are represented on the supported employment groups. As the implementation plans are developed it is our intention to fully involve AHS field staff and to conduct customer focus groups including employers.



# Challenges for Change

Information Technology  
Enterprise Infrastructure

# IT Enterprise Infrastructure Challenges for Change

## **Executive Summary**

---

Technology is a key component of the charge to AHS to redesign its delivery systems to achieve a client centric approach in the “Challenges for Change: Results for Vermonters” January 5, 2010 report to the Joint Legislative Government Accountability Committee. Although redesign efforts have been organized around particular areas or target populations, multiple demands on information technology require the IT professionals both participate in these groups and establish a separate forum for determining the technology needs and priorities.

We can no longer rely on an IT strategy of working sequentially from project to project, hoping that an initial deployment can grow to serve other divisions or departments. Too often we found that solutions were unique and had been designed to fulfill a narrow niche and could not be easily expanded. Our redesign of IT is a redesign of our strategy to implement IT in support of business needs. The result will be faster development of critical technologies, reuse of components across many services, and better and more maintainable systems. These improvements in IT are necessary to support the goals of the functional areas involved in Challenges for Change.

The redesign relies on constructing an enterprise architecture for technology, information and the business of AHS. An enterprise architecture creates a roadmap that can provide guidance for future investments. It is built on the principles and products of a service oriented architecture (SOA) of common technologies and shared services that provide reusable components for various needs. For example, we will purchase and install one master-person index or one imaging solution that is configured for wide utilization across functional areas. A division or program will conduct a business process analysis; and, if imaging and unique identification of individuals, are required, the tools already purchased and installed will be used as part of the IT solution.

More importantly, by purchasing re-usable components, staff members’ skills are transferrable and implementation times will decrease dramatically. In some areas projects that would have been scheduled sequentially, can be accomplished in parallel if resources are available. For example, a business rules engine that can structure statute and policy and translate it to create web-based questions that determine eligibility can be implemented for 3Squares for DCF at the same time the component is being used to structure sentencing rules for Corrections. Over time standard processes will decrease costs in many areas and support more effective business processes.

On a broader level, some solutions are being purchased and implemented for use across state government. AHS IT is contributing to and coordinating with this effort so that common components can be used across all agencies.

### **Goals and objectives**

The goal is to implement systems and install infrastructure in time to meet the needs of the

programs as the AHS service delivery model is redesigned. A key to reaching this goal is to identify all anticipated IT needs and create a plan to successfully implement new technologies while responding to current IT needs in a thoughtful, structured manner. With the new technologies in place, individual projects, some running in parallel, can be implemented to support the redesign initiatives. Transition strategies include:

- **Business Needs Drive Technology Choices**

Create a “technology map” based on the AHS functional areas to provide guidance about the business strategic decisions and directions.

- **Acquire Once, Re-use**

Acquire technologies—particularly enabling technologies—that can be re-used across departments/programs/business functions with minimal modifications while building enterprise capability (e.g., business rules engine, identity management, and imaging). This can be done by 1) implementing a new instance of a common technology or 2) extending the current base to other programs/functional areas.

- **Leverage Platform/Technology Experience and Knowledge**

Build on successful implementations and operational experience rather than acquiring new technologies (e.g., experience with deploying IVR for call center operations).

- **Prioritize Realistically**

Not all things are possible, especially concurrently; high-impact (real savings) projects take priority over minor efficiency gains; business and IT sides must partner on setting priorities.

- **Account for ROI**

Honestly and completely understand the true costs of transformational projects (e.g., required project management, business analysis, process re-engineering, implementation, and support/maintenance resources) on both IT and operational sides of the equation.

- **Leverage Innovative Funding and Align with State HIT Plan**

Initiatives such as Medicaid Management Information System (MMIS) and ARRA provide limited-time windows of opportunity for acquiring and deploying enabling technologies associated with the initiatives. Alignment with the State HIT plan will be required to ensure funding is appropriate and that deployed technologies strengthen these initiatives.

- **Encourage Technologies that are Extensible to Statewide Use**

When evaluating technologies/projects, give priority to those with wider application across other agencies in accordance with Vermont State IT strategic planning and planned initiatives.

## **Information Technology Strategic Plan**

(A) Core components. Many of the deficiencies cited in the Challenges for Change report and visions for the future correspond to the components we have identified as a priority for our enterprise architecture. These priorities evolved from key efforts like Vermont Integrated Eligibility System (VIEWS) and MMIS and include the technologies implemented as part of Strategic Transformation Effective Enterprise Realignment (STEER).

The goal is to move each component to the technology implementation stage with a plan for how the model would be expanded throughout the Agency.

- Stage 1: Acquisition plan for the technology
- Stage 2: Implementation plan (propose proof of concept, pilot or phased rollout(s))
- Stage 3: Technology Transfer Implementations
  - Model expansion, common tool set(replication or enhancements)
  - Licenses and maintenance
  - Vendors
  - System integration issues
  - Internal resource requirements
  - Implementation issues/learning
  - Scheduling

The following critical components have been identified and assigned to these stages:

- Business rules engine – stage 1
- Enterprise Master person Index (EMPI) – stage 2
- CSME data warehouse – stage 3
- Imaging – stage 2
- Call center – stage 3
- Workflow – stage 1
- Web portal – stage 1/2
- Enterprise bus – stage 1

A team was assigned to each component and they created a vision/scope and work plan. For those at stage 1, requirements and acquisition strategy were identified; stage 2, as implementations are being completed documents are to be compiled to help in technology transfer; and for stage 3, document the technology transfer covering the areas listed above, as well as act as consultant to other departments for this technology. Additional work to estimate costs and resources for these components is underway with preliminary estimates included later in the document.

(B) Challenge for Changes specific IT requirements. In addition to the core components, we recognize that each of the subject matter groups may have unique IT requirements that cannot be met by current systems or implementation of a core component. However, to date, none of the groups have developed plans in sufficient detail for them to identify IT needs.

(C) IT changes required because of FY11 budget. System changes and other IT support required to implement the initiatives and cuts proposed in the FY11 departmental budget submissions are dependent on the actual budget that is passed and none have been compiled.

(D) Current projects. A prioritized listing of projects currently underway or proposed, including enterprise projects (VIEWS and MMIS) and division specific projects are being completed by individual departments for inclusion in the plan.

When all tasks are complete, the plan will strive to identify dependencies among projects and complementary projects that can be acted on together. It will produce descriptive data and recommendations for the Secretary and Commissioners to be able to prioritize the projects and apply appropriate resources.

Because of the complexity of capturing this data and the lack of project management tools in use at AHS, the AHS project management group was added as a core team and they have identified a project management toolset to pilot during this process.

### **Outcome/Indicators**

---

IT changes are proposed that will help meet the outcomes and indicators of the business proposals. As IT solutions are developed and implemented to meet the needs of the program changes, separate performance indicators will be developed.

### **Estimated Savings and Return on Investment**

---

Savings accrue to the respective initiatives.

### **Changes Needed in Statute and Regulation**

---

Statute requires an Independent Review for any IT acquisition over \$500,000. (Title 3, Chapter 45, 3 V.S.A., paragraph 2222) AHS requests legislation that would exempt IT investments made in conjunction with the Challenge initiatives including the purchase and implementation of components of the enterprise architecture including Master Person Index, work flow engine, enterprise bus and rules engine. The exemption will sunset at the end of FY12.

Independent oversight of this work will be provided by the State Chief Information Officer (CIO) and AHS will be required to submit written materials that fulfill the components of the independent review to the CIO.

### **Timeline for Planning and Implementation**

---

The only timelines that have been discussed relate to the acquisition and installation of the infrastructure, and only at a summary level. These installations are a precursor to the implementation of new systems using these components that will support the redesign of the programs.

<b>Task</b>	<b>Proposed Timeframe</b>
Confirm acquisition strategy and plan	Last week March
IAPD submission to CMS (for possible 90-10 funding)	1 <sup>st</sup> week of April
RFP issuance	2d week of April

Vendor selection and contract	June
Installation	July - August

This timing is consistent with the issuance of an RFP for MMIS and VIEWS implementation in the July – August timeframe. By then, we will have selected and installed our enterprise architecture which will be defined as the platform upon which the new systems could be built – or will have to integrate with should a vendor propose a hosted or proprietary solution for these programs. This schedule is extraordinarily aggressive and will require total cooperation with CMS and DII as well as waiver from the Independent Review statute.

As various projects are defined, separate implementation schedules will be developed. For example, imaging hopes to be operational in April [will it be]and we hope to have a governance structure in place to accommodate other department’s expansion of the use of imaging. Health has a project well defined with all business process work completed and will be the first to add about 6,000 items concerning paternity to this repository. Because it is so small with one discrete form, we project about a month for implementation.

## **Investments Needed**

---

We are still collecting some rough target numbers for various components and these will have to be updated based on actual quotes as well as the final determination in some areas of the amount of licenses to purchase initially versus those that can be added as we proceed with the implementations; i.e. how much do we need to invest during an initial installation versus costs to increase or upgrade at later dates.

### **Technology Procurement- preliminary numbers**

<b>Product</b>	<b>Estimated cost to procure and install</b>
Enterprise Master Person Index (EMPI)	\$350,000 - \$500,000
Workflow	\$500,000- \$750,000
Business Rules Engine	\$750,000 - \$1,000,000
SOA suite-enterprise bus	\$750,000 - \$1,000,000
Call center	Infrastructure priced by implementation or expansion of existing deployments; each call center has been in the \$80,000 - \$100,000 range
Imaging Services	Expansion of storage costs at implementations
Web services	Infrastructure in place with VIC, costs for development of actual applications with VIC
CSME Data warehouse	Infrastructure in place, additional storage and potential costs for additional licenses or enhancements if user base is extended
Project management (pilot)	\$20,000
Staffing to support core components	\$800,000

### **Human Resources/Staffing Model**

In addition to investment in IT products and personal services to implement various implementations of these products for PSG needs, a new staffing model must be considered to support implementation and operation of this enterprise architecture.

Each application is different and will have different human resource needs. Many of these skills are not held by staff at AHS and we will need to develop these skill sets to be able to support this new environment. The applications also require new duties that will require additional staffing after implementation. We hope to hire interim staff and use them to help alleviate current operational burdens on existing staff so existing staff can develop the new skill sets for this technology.

It is important to reinforce the fact that the resource requirements are not only on the technical side and we will need to reassign or supplement departmental program staff to be able to implement new systems using these technologies. A good part of the effort after procuring the technology is for business process analysis to determine the requirements and define how the technology fits into the redesign systems.

Our overarching vision is to introduce enterprise architecture to AHS. Enterprise architecture covers not only technology but also information and the business/programs. To be successful we will need to introduce an SOA- Enterprise Architecture Governance team that can represent all 3 components, technology, information and business. This may require designating internal staff members to take on these roles, and/or supplementing staff with additional positions.

The staffing model also changes during the phases of acquisition, implementation, and operations. Each team has been asked to create a staffing model that includes both the technical and program resource requirements. Our acquisition model uses a 4-5 member technical team lead by a project manager to define requirements, write appropriate IAPDs, RFPs, select vendor, prepare work plans, begin training to develop new skill sets and install, with the vendor's assistance, the new architecture. This installation may include a proof of concept or pilot in which case an implementation team is required. Resources can vary significantly depending on the acquisition model.

Our staffing plan starts with one IT individual assigned to each component with one additional individual identified during installation as backup and during implementation as full-time to work with implementation teams. If several parallel implementations are underway additional staffing may be required. The goal is to have at least 2 individuals with high knowledge of the application; i.e. 2 each for workflow, rules engine, enterprise bus and related messaging, and EMPI. EMPI will require additional staff to resolve potential duplicates. Depending on how tightly the workflow, enterprise bus and rules engine are integrated, this staffing level might be reduced when the system matures and we are in an operational mode. Across components we expect the need for one highly trained and experienced DBA with a less experienced assistant. Currently we have no experienced DBAs available. The addition of 2 project managers, 2 business analysts and 1 security analyst (to work with the security director) to support the departments efforts during implementation will be needed. This staff does not include project leads and requirements definition participants from the departments and this can be a significant dedication of staff as noted with the work done on VIEWS and STEER.

Operational needs will vary significantly depending on whether the solution is hosted or run in-house.

Help desk support across the agency should be analyzed to determine how best to provide the on-going support as well as testing, training and change management for users. The help desk functions can be critical for successful implementations as well as operations and potentially restructuring the agency approach to this support might provide resources for this type of coverage without additional resources.

## **Information Technology (IT) Needs**

---

IT needs are specified in the investment section.

## **Stakeholder Involvement**

---

A team was organized that consisted of 3 groups:

- Core component implementation
- PSG group IT representatives who are IT Managers of AHS departments
- Programmatic stakeholders who include the chairs of each workgroup as well as the program leads for the key enterprise projects

The IT groups have met weekly, the full group monthly. The leads for each of the core components were asked to set up a small group with mainly technical staff (at first) to set scope and complete preliminary research as needed.

Workgroups will identify additional stakeholders and means to involve them in the process. The weekly meetings have been used to report on status and provide more information on details of the products and functionality. It has given us an opportunity to be sure each group is progressing and we have not omitted areas of work that are needed by the other work groups. We have identified the functional area of identity management (broader than just EMPI) as a function that needs additional research and meetings are being scheduled for that purpose.

Two monthly meetings were held with internal stakeholders to inform and seek alignment with the needs of the subject matter groups and major projects. Discussion has been general and we do not have any clear definition of IT work that may be required for these initiatives. We believe this is because the redesign is still at a high level. We have had demonstrations of product and the web group has had meetings with DII and VIC to plan and coordinate activities. DII staff members are included on many of the work groups and DII representatives have participated in the larger monthly meetings as well.

As we near implementation plans, stakeholders will include more members of departmental program staff.

## **Glossary of Terms**

---

Some of the terms we use may not be familiar to the reader and so we have attached a brief definition.

Business rules engine – Business rules engine is software used to track, manage and revise enterprise business processes. This software system typically executes business rules that might be derived from legal regulations or in-house corporate policies. A business rules engine

registers, defines, classifies and manages all of the rules. It will verify consistency and define relationships between different rules to ensure the uniformity and integrity of the rule sets.

CSME data warehouse – The Central Sources for Measurement and Evaluation (CSME) is a data warehouse tools that combines individual client-level data from different source systems. The extract, transformation and populating of the data warehouse is structured and consistent to provide an unduplicated, aggregate view of AHS clients for planning and decision-making purposes.

Enterprise Master Person Index – An authoritative central repository of individual demographic information and identifiers. It can be used to de-duplicate records and facilitates sharing of information from different applications.

Enterprise service bus – is a centralized infrastructure component that makes a set of reusable services widely available and to communicate with each other. It supports various protocols, can transform data and combine services to create a new service and govern the use of the services based on security rules. [For those who find this definition too technical, if you have seen Avatar, the planet Pandora is analogous to an enterprise service bus]

Imaging services - The representation or reproduction of an object, in this instance unstructured information. Imaging is one module that is part of a larger enterprise content management system (ECM). An ECM is a set of strategies, methods and tools used to capture, manage, store, preserve and deliver content and documents related to organizational process. For our purposes imaging services define the modules purchased to scan and process documents at AHS.

Service Oriented Architecture - is an architectural method or design style that results in and supports shard, reusable services by multiple business entities.

Workflow engine –Workflow is automation of a business process in whole or in part. Workflow dispatches work and sends notifications based on the pre-defined process. It manages the program/business process based on the organization for approval authority, delegation and substitution. It can manage deadlines and priorities and support reporting of workflow status.



Challenges for Change

Corrections Rebalance

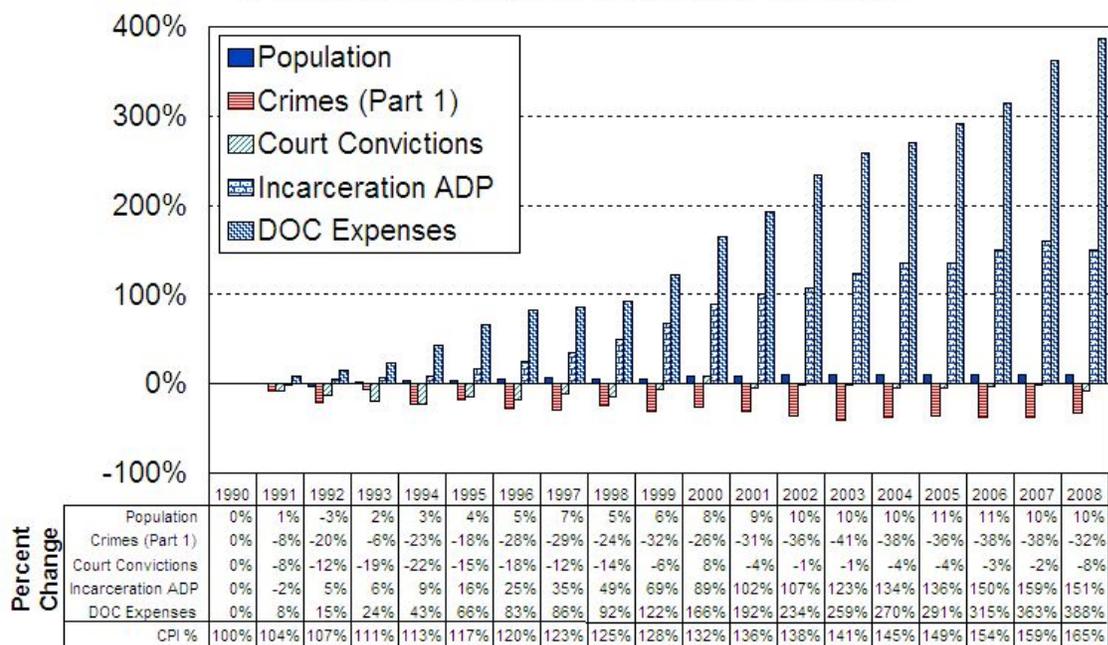
# Corrections Rebalance Challenges for Change

## Executive Summary

In directing a fundamental review in Correctional practices, the Challenges for Change target reduces Vermont’s annual Correctional Budget by \$10 Million. This legislation recognizes that spending on Corrections is crowding out other budget priorities that are important to individual Vermonters and our local communities, such as investments in higher education, agriculture, job development, the environment, human services and infrastructure.

Specifically over the last two decades, Vermont’s population increased from 563,000 to 621,000 or approximately 10%. During the same period, crime rates were essentially flat and our incarceration rates skyrocketed from 850 inmates housed in 1990 to 2,160 in 2009 – an increase of 154%.

## Vermont Justice Measures Percent Change Compared to 1990



Population census/estimates from U.S. Census Bureau (April or July); Part 1 Crime from Vermont Department of Public Safety as reported for FBI Uniform Crime Reports (calendar year); Court Convictions from Vermont Judiciary reports on District Court dispositions (fiscal year); Incarceration Average Daily Population and Expenses from Vermont Department of Corrections (fiscal year). Expenses are not adjusted for inflation.

(Note: data taken from Department of Public Safety and Department of Corrections Public websites.)

Fundamental, lasting change will require a substantial change in culture. Change needs to occur at every level of the criminal justice system and in every branch of government. Over the course of the past two decades, we have come to view incarcerated bed space as an unlimited resource – always available to meet an ever expanding demand without regard to cost. Our real challenge is

to convince not only the criminal justice community, but also the public, that incarcerated bed space is an expensive and limited resource that should be reserved for violent and dangerous offenders and those that habitually reoffend. Our challenge is to build a “unified crime prevention and justice system” consistent with evidence-based practices and a model that uses risk management and community based programming to identify offenders at certain intercept points in the criminal justice system and match them to the program that aligns with their treatment and supervision needs, leading to reduced recidivism and better outcomes. To be successful, we need to build on the recent collaborative efforts of the three branches of Vermont State Government with Justice Reinvestment efforts.

Strategies will need to be implemented to reduce the number of lower level offenders coming into the Department of Corrections' supervision and particularly into costly prison beds. Some of these strategies will include the Judiciary expanding the use of term probation and reducing the term in certain cases, use of judicial summons in lieu of arrest warrants for failure to pay fines, expanded use of community restitution, and the referral/deferral of more cases to community justice centers or diversion boards. We will explore the advisability of combining the resources for this work through a unified program. Additionally, we propose reinvestments into community- based treatment options as well as increasing capacities for drug courts.

Community safety will be enhanced by:

- Building community capacities for structured re-entry.
- Offering increased and newly designed treatment strategies.
- Supporting increased and more specialized transitional housing and support services.

The proposal below is divided into two sections. First are recommendations that our working group discussed and were able to reach conceptual consensus though not necessarily to every detail. This recommendation package includes proposals for savings of \$6,245,640 with reinvestment proposals totaling \$3,164,500. The proposals address 5 of the 7 outcome indicators described in S. 286.

Cost saving proposals include the use of home incarceration as a status (24/7 in the home) and home confinement (allowing for participation in employment, treatment and community service) with electronic monitoring as an alternative to detention, supervised release as a sentencing option in lieu of interrupted sentences, expansion of reintegration furlough, and decreased sanctions for program termination by incarcerated offenders.

Reinvestment proposals significantly enhance community strengths through enhanced workforce development efforts, electronic monitoring technologies to include ignition interlock devices, residential substance abuse treatment, recovery-supportive housing, additional transitional housing for complicated populations, re-entry services that are individually tailored to specific needs, and the expansion of drug court capacity. It also provides funding for a second community based case management and assessment program similar to the Windsor Sparrow Project. It is important to understand that these are not a set of stand-alone options but rather a system of inter-dependent designs that link facilities, field services, external agencies, criminal justice partners, local government, and citizens.

A second set of proposals that would be needed to reach the targeted savings of \$10,000,000 is included in a separate section. The working group did not reach any consensus on these proposals or necessarily discuss them in detail. However the group recognizes that with the FY11 correctional budget already reduced by \$10 Million through the Challenges legislation, broad changes are needed to address this fiscal reality while maintaining public safety.

The additional proposals are premised on limiting incarceration to 1,800 beds. In order to stay below the cap, DOC would be authorized to release incarcerated offenders who have not reached their minimum sentence to a different form of supervision. This would be considered only after a review of each individual's case and circumstances. If released, the remainder of the sentence could be served in a home confinement or home incarceration status as opposed to incarceration in a prison. If alternative supervision is recommended for an offender with over six months remaining prior to the minimum, the Commissioner would be required to inform the prosecutor and the sentencing court of the offender's release on a "supervised sentence" and there would be an opportunity to object to the release. This proposal is modeled after a statute from New Hampshire.

The total savings from both sets of proposals equals \$10,664,000 (before investments), slightly surpassing the Challenges goal.

There are some caveats with this approach. First, all savings estimates for FY 11 are for a full year, which is admittedly aggressive. This presumes that DOC receives the authority to proceed with these ideas before the legislature adjourns and promptly implements the authority to gather a full year savings.

Second, there may be some implications to the DOC contract with Corrections Corporation of America (CCA). If Vermont's out-of-state bed count drops, CCA may object to Vermont falling short of the contractual floor for minimum bed utilization of 400 beds. Recent out-of-state use is 685 beds, substantially above the contract minimum, but these proposals, when combined, will likely lead to utilization below the 400 bed level.

The following are the proposals in approximate order of concurrence.

## **Proposals Developed With Input from Stakeholders**

---

An initial stakeholder working group was able to reach partial consensus on a number of proposals that would produce savings of around \$6.2 million with an investment of approximately \$3.2 million, largely in community-based resources. These are titled *Proposed Savings* and appear immediately below.

Additional proposals were made that would increase the total savings to \$10,664,000 with an additional investment of \$476,128. No consensus was reached to support these proposals, but they are described later in the document in a section titled *Additional Proposals to Meet the \$10 Million Target*.

### **I. Proposed Savings**

- (A) **S. 292 as Proposed by Senate Judiciary Committee:**  
S. 292 addresses Outcomes 1, 2, 3, and 7.

Reduce Detention Beds by 25%	\$1,734,900
Release nonviolent offenders who have served their minimum sentence including DUIs	1,896,824
<b>Total Savings:</b>	<b>\$3,631,724<sup>3</sup></b>

**(B) Decrease Detainee Population (Outcome 7)**

S.292 incorporates savings of \$1,734,900 which requires a reduction of 75 beds currently used for the detention of defendants who have been charged, but whose charges have not yet been adjudicated. In order to make this possible while maintaining public safety, we propose the following:

- Home Confinement through electronic monitoring:** Add home confinement through electronic monitoring as a condition of release to 13 V.S.A. §7554 (a) (1). Further exploration on a monitoring method will occur. Please see section below with respect to home confinement equipment.
- Fast Track Violation of Probation (VOP) merits hearings** and give judges ability to grant use immunity to offenders who have committed new crimes. Many detentioners are offenders on probation who have allegedly committed new offenses which, once adjudicated, may not result in incarceration. Speeding up the adjudication process for the violation of probation, will reduce bed days related to detention.
- Limit use of Arrest Warrants for a failure to pay fine** by requiring judges to use a judicial summons first. If an arrest warrant is required because a judicial summons failed, arrests would be limited to court hours only. (Note: Currently these are not maintained by VCIC— we are exploring the issue.)
- Reduce Number of Offenders Lodged** pre-arraignment by providing training to judges/court managers on how to evaluate pre-arraignment bail requests from law enforcement and developing consistency with respect to the amount of bail that is set pre-arraignment.
- Estimated Savings: Already incorporated into savings from S. 292**, but these steps make the target more practical to achieve.

**(C) Post Plea: Decrease use of Probation/Reduce VOPs:**

(Outcomes 1, 2, 4)

- Expand use of diversion for 2<sup>nd</sup> offenses and low level felony offenses.
- Refer offenders to a reparative board post-plea without placing the offender on probation. If offender completes the reparative board successfully, case is closed without the offender going on probation. If not, the reparative board can return offender to court for sentencing (diversion model).
- Decriminalize DLS offenses unless offense involves an aggravated driving offense. There was not unanimous support for this proposal.
- Set a probation term limit in non-violent felony cases. While there was no consensus on what the limit should be there was on the concept and that the maximum term should be no more than 4 years.

---

<sup>3</sup> Note that this is the savings from the bill as proposed by the Judiciary Committee. An amendment was added in the Senate that reduces the savings by \$ 416,376 by eliminating DUI offenders. It is unclear at this time whether the savings will be restored in the House.

- **Estimated Savings:** There are minimal savings from these proposals that will be reflected mostly in reduced caseloads for field services. A decreased need for field services for probationers could allow diversion of some resources to support supervised community sentences and home confinement as a detention option. These proposals will also send a clear message that probation supervision should be used only for those offenders who really need it.

**(D) Post Plea: Decrease Incarcerated Bed Days (Outcomes 2, 3)**

- **Eliminate mandatory minimums** for all misdemeanors. Currently, there are mandatory minimum sentences for certain DLS offenses and for simple assault when a police officer is involved. Eliminating mandatory minimums recognizes that incarceration is an expensive and limited commodity. The use of incarceration as a penalty should be carefully considered on a case-by-case basis and never used as an across-the-board remedy for misdemeanor offenses.
- **PSI:** Eliminate specific sentencing recommendations in Pre-Sentence Investigations (PSI's) that DOC provides the Court.
- **Reintegration Furlough:** Increase the use of reintegration furlough by extending the length of time that a defendant can be released on a reintegration furlough prior to completion of a defendant's minimum. The current time frame is 3 months prior to completion of the minimum unless the sentence is 180 days or less in which case the time frame is one half of the minimum sentence. We propose increasing the reintegration furlough time frame to six months for sentences which are over one year. The time frame for sentences under one year would be half of the minimum sentence. The DOC's current utilization of reintegration furlough is less than 20%. (Note: an alternative recommendation is that the time frame be one-third as opposed to one-half for sentences under a year.)
- **Supervised Release:** Create a new sentencing option for judges known as "supervised release." This option is similar to pre-approved furlough status, but without a specific programming requirement. A "Supervised Release" sentence would include conditions such as employment and the offender continue substance abuse programming in the community. DOC could use "home confinement" with electronic monitoring and furlough type supervision to ensure compliance. In such a case, based on the restrictions imposed by the Court, the offender may be allowed to leave home for work, community service or treatment. DOC would have authority to incarcerate for violations without going through a violation of probation process. Interrupted sentences (sentences served on weekends usually used to preserve employment) would be eliminated as a sentencing option.
- **Decrease Sanctions for Program Termination:** Currently, under DOC's own policy, the sanction for a termination from prison treatment programming is ineligibility to re-enter the program for 12 months. This results in at least a 12 month increase in an offender's minimum sentence because the offender cannot be released until programming is complete. We propose that DOC reduce the sanction from 12 months to no more than 6 months.
- **Estimated Savings:**

Expansion of Reintegration Furlough

\$1,156,600

Supervised Release Sentencing Option	TBD
Sanction for Program termination	578,300
<b>Total Savings</b>	<b>\$ 1,734,900</b>

- (E) **Decrease Violation Of Probation Filings** (Outcomes 1, 3)
- VOP Sanctions:** Authorize DOC to impose graduated sanctions (such as community work crew service, home confinement or therapeutic intervention) for technical violations.
  - Estimated Savings: Minimal**

(F) **Savings from Investments (see below)**  
Savings over and above the amount invested **\$ 879,016**

(G) **Total Savings Package** **\$6,245,640**

### **Proposals for Re-Investment of Savings**

---

DOC details on a separate spreadsheet investments of \$3,641,000 in FY11. The following were agreed to by the working group. Investments associated with proposals on which there was not consensus are discussed below as potential additional areas to explore for additional savings. **The reinvestment of the \$3,164,500 listed below yields savings of approximately \$0.9 million over and above the amount invested primarily by reducing incarceration.**

Increase in Transitional Housing Capacity (Including beds needed to implement S. 292)	\$1,324,000
Decreased sanctions for program termination	80,000
Expand Community Re-entry services	350,000
Increase Community Capacity Grants	500,000
Electronic monitoring equipment and additional field Services for home confinement and supervised release	910,500
<b>Total Reinvestment</b>	<b>\$3,164,500</b>

### **Additional Proposals to Meet the \$10 Million Target**

---

The savings proposals above fall approximately \$3.8 million short of the \$10 million challenge. DOC offered additional proposals that are not in the list of recommended savings. They are included here for consideration.

- 1. Close South East State Correctional Facility Windsor Work Camp (SESCF):**  
Work camps house non-listed (non-listed crimes as defined by statute) offenders and many work camp participants would be offenders targeted for reduced incarceration in S.292. With insufficient work camp participants Vermont would not be able to populate two work camps, likely leaving one camp empty. This is particularly true if we were able to efficiently add twenty beds to the St Johnsbury work camp.

If the non-listed offender population drops substantially while DOC has not reached the required \$10 million overall savings, DOC would be forced to consider a facility closure. Some staff could be reassigned to available positions including those created through this proposal. All staff would be assisted by the Human Resources Department as was successfully done following the closure of the DALE Women's Prison in Waterbury. The Correctional Industries operation (if DOC retains the DMV license plate contract) would need to be relocated to another facility. There are potential savings related to BGS staff (through their budget). This option would result in savings of **\$2,643,092**. Though not yielding the targeted savings, SESCOF could be re-designated to its former role and operate as a standard facility for male inmates.

- 2. Cap the number of incarcerated offenders at 1,800:** Use of beds would be based on risk and intervention needs as determined by DOC after sentencing. This means a hard cap on the number of beds purchased from Corrections Corporation of America, as opposed to an unlimited cap. **Savings: \$3,839,912**
- 3. Create a "Supervised Release" status** to allow the Commissioner or his designee to manage the population more effectively and stay under the 1,800 cap. The Commissioner or his designee would be authorized to release any inmate who had served at least 1/3 or 60% of their minimum or flat sentence (whichever is more) in accord with public safety and the needs of the Department. The sentencing court, State's Attorney and Defender General would be notified of the release and would be given 10 days to object. If an objection is filed, the court would schedule a hearing to review the release. Savings – see Cap savings immediately above.
- 4. Home Confinement** for all offenders with a minimum sentence of less than 180 day sentences. These offenders would not be incarcerated. Instead, they would be confined to their homes through the use of electronic monitoring with possible permission for employment, treatment or community service purposes. **Savings: \$578,300**

## **Outcome/Indicators**

---

Desired outcomes as defined in ACT 68 as follows:

- 1. Decrease the number of offenders returned to prison for technical violations of probation and parole while ensuring public safety.**
- 2. Decrease number of offenders coming into the corrections system.**
- 3. Increase number of nonviolent offenders (in this proposal defined as an offense that does not constitute a listed crime) diverted from prison into the community while ensuring public safety and providing effective behavior.**
- 4. Decrease in Recidivism**
- 5. Establish a unified crime prevention and justice system**

**6. Increase revenues realized by DOC from programs designed to develop skills of offenders**

**7. Decrease short term lodgings**

The largest outcome from this work will be an overall decrease in the use of incarceration within the Department of Corrections while protecting public safety by maintaining and enhancing supervision of offenders (consistent with their level of risk) in the community. Additionally, as this plan moves forward over the next few years, the number of people who come to the DOC on any status, should decrease, and the use of alternative sanctions by the Courts (reparative board referrals, diversion) should increase. If this happens, people who commit crimes will be dealt with at the lowest level possible and diverted, wherever feasible, away from incarceration. In the past the Department has utilized electronic monitoring and alternative sanctions as deferring or release mechanisms. We believe that these strategies have lessened, though not erased, the rise in incarceration numbers, while maintaining public safety.

**Estimated Savings and Return on Investment**

---

If all the options were selected, full year savings in SFY 2011 are \$10,664,000 with \$3,641,000 in reinvestments for a net savings of \$7,023,000.

**Changes Needed in Statute and Regulation**

---

The DOC proposes the following statutory introductions and amendments:

- Y. Enact S. 292 as passed by the Senate and expand the bill to include the original Senate Judiciary Committee language regarding DUI 3 and greater.
- Z. Amend the reintegration furlough statute, 28 V.S.A. §808(a) (8), to expand its timeframe from 90 days to 180 days for all offenses. As noted earlier, the DOC's current utilization of reintegration furlough is less than 20%.
- AA. Amend 13 V.S.A. §7030(a) to include a sentencing option known as a "supervised release sentence" and prohibit the use of non-consecutive sentences such as a weekend interrupt sentence.
- BB. Enact a statute to create a "Supervised Release" status based on the New Hampshire model.
- CC. Establish home confinement as an optional condition of release to 13 V.S.A. §7554 and home incarceration as a sentencing option for courts. Home incarceration is 24/7 at home, while home confinement allows for participation in employment, treatment and community service.
- DD. Authorize judges to grant "use immunity" to offenders charged with a violation of probation based on new criminal charges.
- EE. Enact a statutory limitation on use of arrest warrants and incarceration for failure to pay a fine or surcharge.
- FF. Authorize referral of misdemeanants to reparative boards at sentencing and authorize the boards to return such offenders to court for further sentencing for failure to comply with board requirements.
- GG. Amend 28 V.S.A. §205(a) (3) (A) to standardize the probation term limit for felonies to a set period of years.

- HH. Eliminate mandatory minimums for misdemeanor offenses by amending 23 V.S.A. §674(b) (DLS) and 13 V.S.A. §1028(a) (simple assault on a police officer).
- II. Adjust caseload ratios for lower level offenders.
- JJ. Combine Community Justice Centers and Diversion Boards to streamline and coordinate their efforts. This proposal was discussed by the stakeholder group as an option to explore for FY12.

### **Timeline for Implementation**

---

Planning has already started regarding offenders who would be affected by this plan. The complicating factor is that in order to save \$10 million in FY11, DOC must act promptly and with ample time to reduce incarceration by the *start* of the new fiscal year. This timeline is admittedly aggressive, but must be adhered to in order to make the stated budget target.

### **Investments Needed**

---

A total investment of \$3,641,000 is needed in FY11 to build or enhance the infrastructure within communities to support and hold accountable re-entering offenders and to divert from incarceration offenders who commit non-violent crimes.

### **Information Technology (IT) Needs**

---

The above proposals will need some adjustments to the DOC data system, however, no substantial investment in the DOC I/T system is planned at this time.

### **Stakeholder Involvement and Process**

---

In addition to Robert Hofmann, Secretary of the Agency of Human Services and the Hon. Amy Davenport, Administrative Judge for the Trial Courts to whom the corrections challenge was specifically issued, the recommendations contained in this report were developed by a work group that included Cindy Maguire from the Attorney General's office; James Mongeon from the Department of State's Attorneys, Matt Valerio, Defender General; Andrew Pallito, Commissioner of Corrections; and Karen Gennette from the Court Administrator's Office. This group met on four occasions and at times was augmented by participation by legislators and Thomas Tremblay, Commissioner of Public Safety. We are in the process of engaging other key constituencies such as victims' advocates, local municipalities/law enforcement, offender advocates and community based organizations. It is our intent to expand this group as we move forward, particularly as we consider the challenge for FY12.